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Hospital Management

The News and Technical Journal of Administration

The ten-foot statue portraying a mother guarding her children is part of the rehabilitation of the lobby of the Cook County Hospital, Chicago. See story on page 14.

January, 1940

New Hospital Construction Bill Proposed by Roosevelt • A.M.A. Approves Cook County Hospital for Internship

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Hospital Management

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VOL. 49—NO. 1 JANUARY, 1940

HOSPITAL MANAGEMENT is published on the tenth of each month at 100 East Ohio Street, Chicago, Illinois, by Hospital Management, Inc. Telephone: Delaware 1337. New York Office: 330 West 42nd Street. Telephone BRyant 9-6432. Southern Representative: B. Frank Cook, Walton Building, Atlanta, Ga., Member of the Audit Bureau of Circulation and a member of the Associated Business Papers, Inc. Subscription, $2.00 a year. Single copies, 20 cents in U. S.; Canada, $2.00 a year; foreign, $2.50 a year. Entered as second class matter May 14, 1917, at the post office, Chicago, Illinois, under the Act of March 3, 1879.

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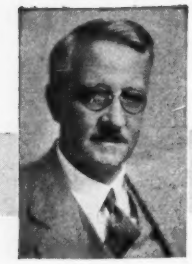

"To Talk of Many Things . . . ."

Indiana Association Gets Trustees Together

Indiana has started a new idea; at least it is new to me. The January issue of the Association's bulletin announced a meeting of township trustees, elected, among other duties, to serve the indigent. Meeting with them were physicians and hospital administrators. The meeting was a get-together to discuss the problems of each group as they impinged on those of the others.

For years I have watched the efforts to induce hospital trustees to attend the annual conventions of the American Hospital Association and have often wondered if they were worth while. A few of the more broad minded and enlightened trustees attend, but the meetings do not reach the ordinary board member. Yet I venture the assertion that there is no person in hospital work who is in greater need of education than the trustee.

Many times I have deplored the lack of contact between the hospital and the physician. Sounds odd when it is put that way, but there is a lack of understanding contact. The doctor comes into the hospital to see his patient, but rarely do we find a staff member who appreciates our administrative difficulties, and all too often we do not try to understand his troubles. We need a common meeting ground, a place where each can forget his own particular trials and tribulations for a few minutes and at least pretend to sympathize with those of the other fellow.

It seems to me that the Indiana meeting is an ideal example of a get-together. The report which I received gives a lot of information about the formal part of the meeting, but says nothing about any informal events. If I know those Indiana people as well as I think I do, I believe that some time was devoted to something beside speeches. In my opinion the most important part of the meeting was the little groups that got together afterward and just talked. They did not solve any problems but they got to know each other.

Try the idea in your community.

The Value of Chance Contacts

It is surprising how often we make a chance contact which turns out to be of infinite value. Perhaps on a train, or in some other place where we are alone, we make such a contact and are surprised to find that our casual acquaintance not only serves to pass the time but also passes it very interestingly because of some particular line of knowledge which he possesses and is both willing and able to impart.

I will always remember a long trip I made when I lived on the West Coast. I was travelling across the continent and did not look forward to the trip with any degree of pleasure. Leaving Chicago, I was pretty well bored with myself and started talking to a fellow passenger in the observation car. He turned out to be the district representative of one of the largest wholesale groceries in the business, one from which I bought a lot of stuff. It happened that he knew canned goods of all kinds from the field to the table, and, as a result, I spent a couple of very interesting days. From that chance contact I not only got an intensive course on the growing, canning and marketing of fruits and vegetables but also I made a close acquaintance who proved very valuable in my later work.

This is brought to mind by a contact I recently made when travelling from the East to Chicago. Opposite me in the Pullman was a man who, like myself, spent the early part of the evening doing some work. About ten o'clock we both finished working and I noticed that he, like myself, was sitting doing nothing, and I invited him to join me in my lack of occupation. He turned out to be a steel supervisor who knew and was willing to tell me a lot about the various grades of steel which we use in hospital work.

Of course there is the other side to this, as to any other, question. Why is it that people, when they find we are engaged in hospital administration, always think it their duty and their privilege to unload all their grievances against the hospital? Some of these are real, most are imaginary; yet we have to listen. This gets under my skin so much that I make a practice of not letting people know that I have any interest in hospitals until I find out something about them. Then, if I find them interesting I let them know that I am receptive to anything they have to offer. Sometimes they give me constructive criticism but more often they furnish information about something with which they are familiar, and usually it is valuable.

Perhaps it is the bore who thinks he has to rake up all the evil things he knows about a hospital which makes us sometimes neglectful of the value of chance contacts, but we never know when one may be both interesting and worth while. In addition, we must always remember that we have great institutions to sell to the general public, that everyone is interested in these institutions and that any chance contact may prove a valuable sales outlet for our hospitals.

Hospitals as Fire Hazards

At the recent press conference, to which reference is made in this issue of HOSPITAL MANAGEMENT, President Roosevelt recommended the building of 50 frame hospitals in the poorer states. I think surely the President must have been misquoted. After all the warnings we have had about the great danger of hospitals which are not built as nearly fireproof as they can be, surely the chief executive of our nation would not deliberately advocate building hospitals which endanger the lives of those confined in their beds.

Any person will recall the disastrous fires that have occurred in institutions of various kinds throughout the United States and Canada during the past decade. An article by T. Alfred Fleming in *Public Safety* calls attention to that hazard as he has found it in several hospitals and other buildings. Speaking of hospitals, he tells of one for epileptics in which 238 children were confined in a building having barred windows and no fire escape. A southern hospital is mentioned in which 36 mothers and nine infants were found on the fourth floor of a frame building with only a wooden fire escape. Other examples are given in the article, but it is unnecessary to repeat them.

There are many hospitals in the country which are not fireproof and which are a constant source of worry to their administrators. All are buildings which were built before modern fireproof construction became the custom and are used under compulsion of necessity. In most instances we are avoiding disaster by constant vigilance, but we all know the danger. I sometimes wonder if we would not be well advised to neglect some of the new appliances we are buying and pay more attention to the ordinary hazards.

Anyway, I cannot believe that the President would deliberately advocate building hospitals which are a fire hazard. Either he is misquoted or he has spoken with undue consideration of the results. On more deliberate consideration he will certainly change his policy, if the frame building is his policy, and provide for construction that is at least slow burning. Better to cut the size of the hospital in two and make it twice as safe. I do not believe that even a great anxiety for the health of the people would justify placing their lives in danger in order to further their health interests.

John Gaston Hospital Pharmacy

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LINES AND LETTERS

General Practitioners

To the Editor: *I have just read your editorial on "General Practitioners." Strange to say, I had already brought this matter up before our Board of Directors and they had asked our staff to form such a division. This will come up at our next staff meeting in January.*

I wonder if you can send me the article you speak of in your editorial on page 29. If you do not have it, I will greatly appreciate it if you will write the publishers and have it sent to me.

ROBERT JOLLY,
Administrator

Memorial Hospital
Houston, Tex.

We think the organization of a general practioners group in the medical staff is going to be a pretty general move. One thing that is puzzling us is how we are going to use them. We have thought of making the general practitioners the biggest group in the staff, assigning all cases to them except those that should be classed under some of the special services, and using the specialists as consultants. If anyone arrives at any other solution, we should like to hear about it.

Vacations

To the Editor: *What would you suggest as a fair vacation for the instructor of the nursing school who is leaving at the end of her year's work? I am referring to the vacation plan as it was accepted by the A. H. A.*

M. H.

This letter brings up one of the old debated points about which we have always taken a rather definite stand. We believe that a vacation should be regarded as a bonus at the end of a year's work and not as preparation for the next year. We have, therefore, always given employees their regular stated vacations whether they were leaving the service or not. Apart from regarding the vacation as something the employee has earned, there is another feature which has to be considered. If a vacation is given as a preparation for the coming year, some employees will take their vacations, come back on duty for a short time and then resign with a minimum of notice. This generally puts the employer in a very awkward position and it is one of the reasons why we have always followed the other plan of action.

Revision of Nomenclature

To the Editor: *In your column, "To Talk of Many Things" in the December issue of* HOSPITAL MANAGEMENT, *I noted with interest your comment on the proposed revision of the Standard Classified Nomenclature of Disease scheduled to be undertaken by the American Medical Association in* 1940.

At the present time, we, in our hospital, are employing the Massachusetts General Nomenclature and over a period of years have found it quite satisfactory. However, recently much consideration has been given to the employment of the Standard Nomenclature, the proposal having reached the extent of a provision in next year's budget for the installation.

I would appreciate having your opinion on whether or not any revision of the Standard Nomenclature made by the American Medical Association would be sufficiently extensive to warrant waiting until its completion. It is perfectly possible for us to hold off for an indefinite time any such transfer and in view of the proposed revision, it perhaps would be the wisest alternative.

W. L. WILSON, JR.,
Superintendent

The George F. Geisinger Memorial Hospital, Danville, Pa.

The revision of the Nomenclature of Diseases and Operations is now under way and the wheels are moving pretty fast. We are informed that a great deal of work has been done on the revision of the Nomenclature of Diseases, and the revision of the Nomenclature of Operations is also under way. The American Medical Association wishes to have as much as possible of this material ready for adoption at the Conference March 1.

Of one thing we can be certain. There will be a revision as soon as it is possible to get it done and get it done correctly. All the nomenclatures need revision very badly and we think anyone would be very ill-advised to make any change at the present time. There can be no doubt that the newly revised nomenclature will become universal and if a change is made now, additional changes will have to be made within a year.

A Question of Technique

To the Editor: *In the November issue of* HOSPITAL MANAGEMENT, *I noticed a letter under the heading, "A Question of Technique." The writer asks for information as to how to avoid the rusting of instruments that are kept in alcohol.*

The following procedure, as carried out in this hospital, might be of interest:

All needles used in the operating room, also hypodermic needles used throughout the hospital, are kept in a solution of alcohol 50% and a very small quantity of soda bicarbonate. This solution is changed once a week.

Since adopting this procedure, we have had no trouble whatsoever with needles rusting.

MARGARET MURDOCH, R. N.
Superintendent of Nurses
Saint John General Hospital
Saint John, N. B.

Care of Terrazzo Floors

To the Editor: *I would appreciate any material that you have on the proper care and maintenance of terrazzo floors.*

The terrazzo in our hospital is about 30 years old and seems to have assumed a sort of dirty, dingy appearance. While we have been able to brighten this up somewhat with sandy abrasives, we have never been able to put on the type of covering that would seal the pores and prevent it from getting dark again without getting a slick surface. Of course, during dry weather it is not dangerously slick, but in the event that you have wet feet when you first come come in on the terrazzo floor, it is entirely too slick for safety. We will greatly appreciate it if you can give us additional information.

A. C. SEAWELL,
Assistant Superintendent.
Baylor University Hospital,
Dallas, Texas.

Usually a thin coat of wax will seal the pores and keep the floor glossy. The wax should be applied in a very thin coat and polished hard. The chief reason for slippery wax floors is that too much wax is used. There are a number of liquid waxes and varnishes on the market which are satisfactory, and I would suggest getting in touch with one of the makers of paints and varnishes.

Has anyone a better suggestion?

Hospital Management

JANUARY, 1940

President Roosevelt Proposes New Plan for Hospital Expansion

By DAVID HILL, JR.
Washington Bureau, HOSPITAL MANAGEMENT

A merry behind-the-scenes battle in Congress and in high administration circles is shaping up over President Roosevelt's announcement on Dec. 22 that he favors the substitution of a modest hospital construction program for the broader and much more expensive long-term national health program called for by the Wagner National Health Bill.

To fully understand what lies ahead we must go back several months to pick up the thread of the story. Ever since the adjournment of the hearings on the Wagner bill before the Murray sub-committee of the Senate Education and Labor Committee last July, experts from interested government departments, particularly the Social Security Board and to a lesser degree the Public Health Service, have been drafting amendments to iron out the wrinkles which were shown up in the bill. A few weeks before Congress convened on Jan. 3 the amendments were practically ready and plans were ripe to revise the Wagner bill, offer it to the full Education and Labor Committee and put on the pressure for a prompt and favorable report to the Senate.

Senators Irked

But the President tossed a monkey-wrench into the machinery of these carefully laid plans and in so doing has alienated the good will, temporarily at least, of the two key Senate figures in the health fight, Senator Murray of Montana, chairman of the special health sub-committee, and Senator Wagner, author of the National Health Bill.

At the session's opening both senators were considerably irked because neither the President nor the Interdepartmental Committee had called upon them for their views on the proposal to shelve the Wagner bill in favor of the simpler and less expensive hospital construction program.

Now this reaction is important because while the original impetus for a national health program and the first drafts had come from the President upon the recommendations of the Interdepartmental Committee, Senators Murray and Wagner have felt increasingly that the program was their particular legislative "baby" and that they should be consulted on every move made. The effect of these attitudes on the enactment of any program is important because Senators Murray and Wagner will be the chief pilots for any health program which goes through the Senate. If the administration alienates the good will of the two leaders the effects may be far-reaching.

May Fight Over Wagner Bill

Furthermore, the health program is now technically out of the hands of the White House and Interdepartmental Committee and is squarely in the lap of Congress. While there is no question but that the legislators will follow suggestions of the White House and the Interdepartmental Committee, there is also the very definite indication from Senators Murray and Wagner that they may not abandon the Wagner bill and may press for its consideration regardless of the attitude of the White House.

That is where the fight will come, if it develops at all. The legislators hold the whip hand in any program because it must go through Congress first. On the other hand, unless the President and his budget bureau approve the expenditure of any money for new programs, the legislators are stymied.

The lines in the conflict are not yet clearly drawn. Senators Murray and Wagner are waiting to see what kind of hospital construction program is drafted and recommended to the President by Josephine Roche and her Interdepartmental Committee. When the President approves and then submits the recommendations to Congress it will become the sphere of Senators Murray and Wagner to decide what becomes of them.

President's Announcement Vague

Remember that the outline of the program launched at the White House press conference on Dec. 22 is exceedingly vague and was definitely not the announcement of a well thought out or detailed program. The President himself indicated that. Only when the Roche Committee completes study of the President's suggested outline program will the situation be clearly shaped.

In the meantime what the President did suggest bears careful study. In the first place, he said that a modest program of hospital construction should be launched almost immediately and in areas which now lack adequate hospital facilities and where such hospitals can not now be financed locally.

At the outset about 50 such hospitals might be started in areas which would be selected by a "committee of distinguished doctors." No sites could be selected without the approval of this committee. The President estimated that the average cost of such a hospital, to accommodate about 100 beds, might run around $150,000 if constructed of lumber. General floor plan might be for a one-story building of two wings with a clinic and administration office in the center.

He was careful to offer this only as a suggestion, however, and gave no concrete estimate of the overall cost of any hospital envisaged by the program.

Federal Government to Bear Cost

Certain definite conclusions are held by the President, however. Chief one is that the federal government shall pay all the costs of construction. There would be no matching of funds as provided in Title XII of the Wagner bill, which calls for the construction of hospitals and medical centers at a federal cost of $8,000,000

New Plan Proposes to Build Hospitals for Needy Regions

At a press conference on December 22, President Roosevelt advocated a program of federal construction of hospitals and medical centers, particularly in communities of poor states which now lack them. The President suggested that the hospital program be started modestly, and indicated his belief that 50 hospitals, each one to cost approximately $150,000, should be the goal for the present. He proposed that a committee of doctors select the localities where the need for hospitals is greatest.

According to the proposed plan, the federal government would pay all costs of construction and then turn the institutions over to local groups who can give assurances that they could operate them. Title to the buildings, however, would remain in the federal government.

The probable trend of this legislation and some of its political ramifications are reported in the accompanying article by David Hill, Jr., of HOSPITAL MANAGEMENT's Washington Bureau. Opinions of several hospital administrators on the proposed plan are also published in this issue.

While Mr. Hill feels that the program will encounter a considerable amount of political interference before it is finally worked out, we believe that the new plan is so great an improvement over the former program that it gives a ray of hope that sane and effective legislation will be ultimately adopted. In any such plan, however, we strongly advocate that hospital administrators be included on the advisory committee selected.

the first year, $50,000,000 the second, and $100,000,000 for the third, and wherein the federal government would pay the operating costs of such hospitals for three years. The institutions, under the President's plan, would be turned over to the local authorities as soon as they could guarantee operation and maintenance costs. But title to the hospitals would remain with the federal government.

The President favors this policy for the reason that the areas needing the hospitals most would not be able to meet the fund matching requirements of the Wagner bill and that unless the hospitals were built completely with federal money, those areas would continue without hospital facilities. He made it plain that he was thinking chiefly of certain areas in southern states, presumably in rural sections.

Money to Come from FWA

Money would be made available through the newly set up Federal Works Agency, which took over the PWA under the first major reorganization order of the President, and, wherever possible, labor would be provided by the WPA. It will be recalled that considerable hospital construction, modernization and remodeling has been carried on by both PWA and WPA. Estimates of yearly WPA grants for hospital construction run as high as $50,000,000.

Under the President's suggested program the U. S. Public Health Service would come in for considerable work in making plans and surveys for areas which need the hospitals and also in the supervision of operation once they are built.

Would Prove Politically Popular

If the Interdepartmental Committee finally recommends the adoption of a program such as the President has outlined it is certain to prove popular politically. Remember, current Congressional business is being conducted to a greater extent than ever in an atmosphere of practical politics. And what the suggested hospital building program holds in the way of Congressional "log rolling" and "pork barrel" spending program is an important one.

Certainly legislators, particularly those from states which have deficient hospital facilities, would work together voting federal projects which would cost their individual states nothing directly, and log-roll through a mammoth hospital program and would select the sites for construction despite what any committee of distinguished doctors might have to say about it. The chances are that such a program would rival the famous "rivers and harbors projects" as juicy "pork barrel" morsels. Congressmen will be quick to see the advantage of projects for their districts without direct cost to the constituency.

This is important because remember also that the President cannot use an "item veto" in any eventually passed bill. He must veto a bill in its entirety or not at all. Therefore if Congress takes the bit in its teeth and votes a hospital construction bill, specifying hundreds if not thousands of projects, which is its usual habit in "projects bills," the President would either have to veto the entire measure or let a bill become law which might cost even more than the hospital construction program envisaged in the Wagner bill.

Future Highly Unpredictable

Consequently, the future of the federal health program in the present Congress is still highly unpredictable. It will continue to be until the Roche Committee reports on this hospital building program.

Some generalization can be made, however. There is little doubt that the administration has dropped the enactment of the Wagner National Health Bill, as presently written, from its program at the present session of Congress. The program is too costly.

In the second place, however, there is no assurance that proponents of the Wagner bill will let the program go by the boards without a fight. And the fight may come over the substitution of the President's suggestions for the Wagner bill.

In the meantime the special health sub-committee of the Senate Education and Labor Committee will mark time waiting for the recommendations of the Interdepartmental Committee. Said Senator Murray late in December before a joint meeting of the American Statistical Association and the American Association for Labor Legislation in Philadelphia: "Our committee will carefully study any plan which may develop from the President's suggestion."

Senator Murray had other comments to make on the President's program. Said the Montana senator: "Last week, the President himself

(*Continued on page 56*)

Hospital Authorities See Weaknesses in President's Proposed Plan

The announcement of President Roosevelt's proposal for federal financing of the erection of small hospitals in selected areas too poor to erect their own was so lacking in details that it has been impossible for anyone to accurately evaluate it. Comments received by HOSPITAL MANAGEMENT this month, however, indicate that a study of the small amount of information given through news releases has raised serious questions in the minds of hospital executives.

The opinions expressed by Dr. Lucius Wilson of John Sealy Hospital, Galveston, Tex., are typical of those received from hospital administrators in every section of the United States.

"If a community is too poor to erect its own hospital," Dr. Wilson writes, "it most likely will be too poor to properly finance one erected by the government. No doubt, there are many communities in the United States in which assurances can be obtained that hospitals erected by the government will be operated, but it is doubtful if these assurances would stand the test of time.

"Should a community find itself unable to meet the obligations it has undertaken, one of two conditions will result. Either the government must operate the hospital at its own expense or permit the community to operate it in an underfinanced manner. The first condition will be an extension of the government entrance into competition with voluntary hospitals; the second will result in the tendency to lower the standards of hospital service.

"Another question of vital importance is the obtaining of the proper personnel in poor communities to operate the hospital.

Why Not Support Existing Hospitals?

"Would it not seem wiser," Dr. Wilson continues, "for the government to allot the money the President proposes to use for this project to support voluntary hospitals already in existence? A program could be worked out whereby the needy sick of the poor communities could be transported to existing hospitals, receive adequate care and the hospital benefit by the money obtained from the service it renders. It is difficult to understand why the government during the past few years has consistently proposed to build new hospitals when today there are so many unoccupied beds in the United States. Unoccupied beds mean loss of revenue, and loss of revenue means difficulty in maintaining high standards. If the effort that has been exerted by the government toward erection of new hospitals could have been directed toward the support of hospitals already in existence, a great public service would have been accomplished and the health needs of the people more adequately met."

Need for Rehabilitation

The comments of Asa S. Bacon, superintendent of Presbyterian Hospital, Chicago, are along the same trend: "Recent surveys have shown that, with possibly few exceptions, the need is not to build new hospitals but to take over poor, small hospitals and rehabilitate them to give proper service. This should be done regionally rather than by counties. Modern transportation favors this. However, there should be a careful survey by competent people to show a definite need in the regions where these small hospitals exist and to show that the community will be willing and able to support them after they are rehabilitated and the government turns them over, for the cost of rehabilitating or establishing these hospitals is small as compared with the cost from year to year of administering them."

Dr. E. T. Olson, medical director of State University and Crippled Children's Hospitals, Oklahoma City, Okla., sees one serious stumbling block in the proposed plan. "Maintenance of the hospitals by the community—in this state, anyway," he points out, "would be a serious problem. Several Oklahoma communities have been unable to meet maintenance cost of municipal hospitals and have turned them over to private interests.

"To my mind," he continues, "the subject of adequate medical care for the indigent does not lie in the construction of more hospitals, but rather in the full utilization of all empty beds in existing hospitals, with payment for the care of such patients therein by some governmental agency. Any money appropriated by Congress should be largely used for this purpose.

"At the present time a large number of communities are even unable to compensate private or community hospitals for the care of indigent patients for which they are asking these hospitals to provide. Few cities require additional new hospitals, and in such cities where the indigent do not receive adequate care, it is prob-

ASA S. BACON

". . . the cost of establishing these hospitals is small as compared with the cost of administering them."

E. T. OLSEN, M.D.

". . . Maintenance of the hospitals by the community, in Oklahoma anyway, would be a serious problem."

ably due to the fact that the hospitals are unable to provide this care without compensation because they are unable to carry this additional burden and because the city is unable to compensate the hospital adequately, if at all.

"For a number of years practically every community or privately owned hospital in this country has had difficulty in maintaining itself because of lack of income and a reduction of income from endowment funds which would ordinarily be used either for the care of indigent patients or the maintenance of the hospital. It is well known in the hospital field that the imposition of the additional heavy burden of indigent cases and the loss of nominal hospital income during this period has made it necessary for many hospitals to close their doors.

"In most cities or communities financial support to maintain additional new hospitals in a proper manner would not be available. In most smaller towns or communities construction of even small hospitals would impose an additional burden upon the town or community which it could not meet.

Would Personnel Be Adequate?

"In addition to this problem, the necessary skilled technicians and adequate staff specialists in all of the necessary branches of medicine would not be available in the smaller communities. Hospitals alone are of no value. They must be manned by an adequate personnel, trained administrators and technical personnel, and last, but not least, a professional staff competent to provide attention for all classes of cases.

"The largest number of patients in any community could, when necessary, be transferred to a nearby hospital without harm. Those unable to be transferred could be cared for by their local physician or family physician in their home with just as good care as could be furnished by the same physician in a hospital which the community could not adequately support.

"In my opinion, therefore, if money is to be appropriated by Congress for the better care of the indigent sick, it should be allocated for the use of existing hospitals in payment for care of indigent patients at not less than the average per capita diem cost of the hospital."

The situation in Colorado is described briefly in the comment received from Dr. Maurice H. Rees, superintendent of the University of Colorado General Hospital, Denver: "In Colorado we have 100 hospitals well distributed. Our need is not for new hospitals but for better support of the existing hospitals. If such support could be obtained, Colorado would have ample hospitalization. There are probably a number of localities in the United States in need of new hospitals," he adds, "but the big problem would be to support such institutions after they are constructed."

Maintenance Is a Problem

The dangerous part of the plan, in the opinion of Dr. A. J. Hockett, superintendent of Touro Infirmary, New Orleans, is where the government turns over the maintenance of the hospitals to local management. "Both the medical profession and hospital people agree that the federal government should assist in the construction of hospitals in the poorer states," he asserts. "The matter of turning these institutions over to 'local groups' is the point of danger. The personnel to be appointed and the standards to be required should be clearly defined. This is a matter which is not simple of accomplishment but which is entirely possible if the medical profession and those sponsoring the project work in close harmony with the aid of sound professional advice."

Dr. A. C. Bachmeyer, dean of the University of Chicago Clinics, raises the point that if local groups cannot participate in the cost of construction, how can they be expected to give assurance that they can maintain and operate the building. "There is no doubt," he writes, "that there is need for the extension of hospital service in certain areas, but the situation requires very careful study from many angles. The President's announcement indicates that such study will be made. The plan, therefore, merits careful consideration and the cooperation of the various national hospital organizations."

Skepticism about the proposed policy to turn over the management of the institutions to local groups, is also indicated by Dr. Fred G. Carter, superintendent of St. Luke's Hospital, Cleveland, and president of the American Hospital Association. "It might be well," he says, "to get the assurances first and attend to the construction afterwards."

He adds: "The modesty of the President's program is in strong contrast with the ambitious proposals of the Wagner Health Bill. If enacted into law it will be somewhat in keeping with one of the recommendations of the Joint Conference Committee of the national hospital associations which suggests that in the implementation of a National Health Program it might be wise first to acquire experience through the utilization of small experimental areas where ideas could be tried out before wider applications are undertaken.

"I like the implication that the need for these hospitals would be determined by those who are qualified to have an opinion regarding such needs. Certainly hospital administrators should have a prominent part in helping to determine these needs."

Goldwater Praises Plan

The President's proposal was greeted with high praise by Dr. S. S. Goldwater, Commissioner of Hospitals of New York City and former president of the American Hospital Association, who said, according to a recent newspaper interview:

"The President's proposal seems to be the most reasonable approach thus far made to the problem of filling in gaps in the organization of needed medical service.

"The program suggested by the President seems to be well within the means of the government, which could hardly be said of some of the earlier proposals that have come out of Washington.

"The choice of locations for the proposed hospitals presumably will be made by competent committees on the basis of demonstrated need and of local inability to provide required capital.

"The adoption of the policy of entrusting management of the hospitals to the communities which they serve indicates that the President has grasped one of the most vital failings in hospital administration.

"More than thirty years of experience in the administration of both voluntary and government hospitals both as single units and in centrally controlled groups has convinced me of the advantages of administering a hospital from within rather than from without. The more remote the control of appointments and of essential hospital administration and policies, the greater the danger of mischance.

"Hospital administrators recognize the need of regional coordination of neighboring hospital units, but such coordination can best be accomplished by regional councils organizing on a voluntary basis with a minimum of external bureaucratic control.

"The President's proposal should put an end to factional differences in the medical profession. It merits the unreserved support of hospital administrators, public health officers and the practicing profession."

Interns in small groups make ward rounds with a member of the attending staff or with a resident.

Cook County Hospital Reinstated for Intern Training by A.M.A.

Cook County Hospital, of Chicago, one of the largest institutions in the country maintained by a governmental body for the care of the indigent sick, was reinstated last month by the American Medical Association as a training center for interns.

This action followed the appointment by the county board of Dr. Marshall Davison as the hospital's new medical director, succeeding Dr. Karl A. Meyer. The administrative set-up, now in effect, places Dr. Meyer as superintendent of all Cook County institutions and leaves General Manus McCloskey as warden, a title which is undesirable but which is fixed by legislation. Associated with the General, and nominally under him, are the medical and nursing departments, the warden retaining direct control of the business management.

Lack of Equipment Criticized

For many years there has been considerable controversy about the standing of Cook County Hospital. One of the criticisms formerly directed against the hospital was the lack of equipment necessary for the proper care of the patients admitted. Although much remains to be done, this task has been remedied to a certain extent, Dr. Davison told HOSPITAL MANAGEMENT in a recent interview. The department of radiology has been completely rehabilitated. Six new diagnostic machines have been installed; therapy is separated from diagnosis, and the department is operating at full efficiency under the supervision of Dr. M. J. Hubeny. While ward equipment is not yet up to the desired standard, the absolute necessities have been supplied and more is constantly being asked.

Another criticism of the hospital in the past was the inadequacy of the nursing service. The quality of the nursing staff was never criticized, but the number employed was insufficient to assure proper care of the patients. This has been remedied, Dr. Davison pointed out, and in the number and quality of its nursing personnel Cook County now rates close to the top among large hospitals.

The number of nursing hours per patient has been greatly increased, the average throughout the hospital, as of November, 1939, being 5.25. A breakdown of this figure, in some of the departments, is as follows: children, 2.7; genitary-urinary and dermatology, 1.92; medical, approximately, 2; gynecology, 2.11; obstetrics, 4; surgery, 1.85; tuberculosis, 1.51; and neurology, 2.29.

At the present time, the medical staff consists of the following divisions: attending, associate, resident, senior intern, intermediate intern and junior intern.

All physicians on the attending staff are on the faculties of one or other of Chicago's five medical schools and are Civil Service appointees. Members of the associate staff are appointed by the deans of these schools.

The number of residents has been increased to 79, of which 39 are allocated to medicine, nine to surgery, six to the psychiatric division, three to X-ray and the remainder to other services. Ten first year residents are not assigned to any special service, but are in various departments of the hospital in preparation for regular service. Residency is for

A corner of the medical library at Cook County Hospital, recently enlarged and refurnished by the Interns' Alumni Association.

One of the large wards in Cook County Hospital in which female medical patients receive care.

three years, the men being appointed annually with the possibility of being reappointed.

The number of interns is fixed, there being 34 juniors, 34 intermediates and 34 seniors on the staff at all times. The training period now consists of three six-month semesters, but the internship will probably be increased to two years.

Plans are being made to include a research division to the medical staff, the members of which will probably be called fellows. There are several such research workers now in the hospital, and it is expected that this department will be authorized within the near future. This will present an opportunity to make use of the vast amount of clinical material that is available. This division should eventually prove to be a very important addition to the organization.

Teaching of medicine is a predominant activity, and students from all five of Chicago's medical schools attend clinics at the hospital. Under the supervision of the attending staff, stated clinics are held, which include both large and small general clinics, group clinics, bedside clinics and ward rounds.

Training for Interns

A very definite program for teaching interns has been established under the new organization. Interns come on duty on Jan. 1 and July 1. Following a physical examination, they are initiated into the specific requirements of the hospital, including the admission and discharge of patients, routine treatment procedures, and the specific mechanics of the organization.

Formal instruction consists of a series of lectures, which the interns are required to attend. The lecture program is outlined by the heads of the various departments, a certain number of lectures being allocated to each of the various services. As an example, there are three lectures on dermatology, 12 on surgery, 18 on medicine, four on urology and five on gynecology. Another feature of the intern's instruction program consists of 24 request lectures, sponsored by the hospital's Intern Council. These are lectures on specific topics suggested by the interns themselves. All add up to over 100 hours of didactic instruction.

In addition, the interns are required to make daily ward rounds with a senior or a member of the attending staff. They also attend the various clinics held by the members of the attending staff, although this is not obligatory.

Tells of Need for Expansion

The big needs of the hospital, according to Dr. Davison, are more room and more equipment. The biggest problem is the handling of the individuals who do not belong in an acute general hospital but rather in a convalescent hospital. Plans were drawn last year for a 500-bed convalescent hospital. However, this was not passed at the last election, and it is problematical, Dr. Davison pointed out, whether the proposed 500 beds would be enough.

Approximately 500 of the 3,300-odd patients in the hospital could be moved to such a convalescent hospital, he said, and the cost of their care to the county would be less than half of the present per diem cost of $4.00.

Almost as urgent is the need for a new communicable disease hospital, an obstetrical hospital and adequate out-patient facilities. The city's bed capacity for communicable cases is much lower than it should be. The hospital's obstetrical department is badly overcrowded, and the facilities for the out-patient department are woefully inadequate.

No real provisions have ever been made for suitable out-patient care at Cook County. The present department developed from necessity from follow-up work. Formerly, out-patients were referred to the various medical school dispensaries; now, the medical schools refer these patients to the hospital, and there is no room or equipment to handle them there. This will be rectified somewhat by the rehabilitation of the old West Side Hospital, located across the street from Cook County's main building, which will be completed within the next thirty days and which will be entirely an out-patient building.

While these improvements to Cook County Hospital are chiefly of local interest, its former standing as one of our great educational centers has given it national standing and there is no person interested in medical education who will not welcome its rehabilitation.

Cook County Lobby Being Modernized

A white marble-cement statue of a mother guarding her three small children has been mounted in the center of a new eight-foot pool in the lobby of the Cook County Hospital, Chicago (see front cover). Ten feet high, the statue is entitled "Protection," and is the work of Charles Umlauf, WPA sculptor.

This and other construction work in the lobby is part of the rehabilitation program undertaken to create a favorable psychology of "first impressions," according to County Commissioner Frank Boyrytzke, chairman of the hospital committee.

The statue, as well as paintings that are being cemented in the walls around it, will be illuminated by a floodlight in the ceiling of the second floor, and water will be cascaded over the sides of the statue pedestal into the pool.

The old-fashioned booths where patients' records were formerly kept are to be replaced by vari-colored ceramic counters, behind which small patient history cards will be filed. Old wooden benches are being replaced by twelve 20-foot wide marble and cement benches. The present bare walls on all sides of the lobby will be brightened with carefully selected framed paintings.

Peoria Plan Moves To Larger Quarters

On its third anniversary, the Central Illinois Hospital Service Association moved its officers to larger quarters in the Central National Bank Building, Peoria, Ill. Since its organization in December 1936, the Association has grown to a membership of more than 11,500 persons.

Greater New York Group Will Participate in Safety Meeting

The rapidly growing hospital accident rate has caused the Greater New York Hospital Association to take an active interest in procedures designed to reduce mishaps among hospital employees, and it was decided at the December meeting of the Association to participate in the annual convention of the National Safety Congress, to be held in New York in March. There will be a hospital session at the meeting which will present specific material bearing on the problem of accident prevention in the hospital.

Speakers at the New York group's meeting pointed out that there were in the past year 625 compensable hospital accidents which cost insurance carriers over $100 each, average, as against a total of approximately $34,000 in premiums paid, demonstrating clearly that unless the alarming upward incidence of accidents to hospital employees is arrested at once insurance rates will soar to much higher levels. In fact, one speaker asserted that while the rate has already gone up from 42 cents to 60 cents it must go higher.

John Olsen, superintendent of Richmond Memorial Hospital, Staten Island, N. Y., who is chairman of the Greater New York Group's Safety Committee, urged cooperation with the National Safety Council in its convention and otherwise, and is preparing to push the hospital session actively in order to secure the largest possible attendance.

Accident Study Made

A study of the accident record taken from a cross section of the leading hospitals in the Metropolitan district has been made by the Association's Hospital Advisory Committee, and the results were presented at the December meeting. There were 479 accidents during the first nine months of 1939, of which 214 were lost time cases. This compares with 461 accidents, of which 208 were lost time cases, during the same period of 1938. A breakdown of the average of each 100 accidents reported by these hospitals during this period is shown in the accompanying table.

This comparison shows that the rising trend of accidents in 1938 continued in 1939 both as to frequency and severity, and therefore definitely establishes the need for a standard, simple and practical program that may be adopted in all hospitals for accident prevention.

The committee urged superintendents to appoint supervisors in each department who would be required to make written reports of all accidents that occur in his or her department, and suggested the following code of safety regulations for the supervisors:

Suggested Safety Code

1. Make careful periodic examinations of the safety conditions under your supervision to include all equipment and apparatus on which any person may become involved in an accident.

2. Report any slippery walkway surfaces and caution employees to watch their step.

3. See to it that all employees wear safe clothing and safe footwear at all times.

4. Clear, safe housekeeping must be maintained at all times to prevent anyone striking against furniture or objects, tripping and falling.

5. Make sure that every employee under your supervision is suited, both physically and mentally, to the work you have assigned.

6. See that employees are carefully instructed and trained in the correct way of doing their work and follow up with effective safety supervision.

7. Most accidents are caused by somebody's negligence. Your constant attention should prevent that in your department.

8. All injuries, however slight, should receive prompt first aid treatment.

9. When an accident does occur, investigate at once and make your report in writing to the superintendent.

10. Supervision of your employees for accident prevention is a definite part of your responsibility. We need your help, and, through you, the cooperation of all employees to make a good safety record.

Accident Summary from Jan. 1, 1939, to Sept. 30, 1939

Cross-Section of Leading Hospitals in New York City

Type of Accident:	*Lost Time*	*No Lost Time*	*Total*	*Percent of Total*
Handling objects	16	22	38	
Falls of persons	10	9	19	68%
Stepping on and striking objects	4	7	11	
Handling tools	3	7	10	18%
Falling objects	4	4	8	
All others	8	6	14	14%
	45	55	100	
Occupation of Injured:				
Professionals	13	14	27	27%
All others	32	41	73	73%
	45	55	100	
Injury Sustained:				
Hand	18	25	43	
Body	11	8	19	73%
Arm	3	8	11	
Leg	4	5	9	
Head	2	4	6	20%
Foot	3	2	5	
All others	4	3	7	7%
	45	55	100	

Serious Accidents:

Fractures 36
Hernias 6
Dismemberment 1

Total reported accidents—479. Lost time cases—214.

Visualize the Hospital of the Future In Modernization Plans

By PERRY W. SWERN
Perry W. Swern and Associates, Chicago, Ill.

When the historians of the future compress the events of the days of our years into a couple of pages of history posterity is going to think that we lived in a whirlwind. Reflect on the developments in the last decade. Imagine the surprise that most of our grandfathers would experience if they could drop in for a visit.

All of this has had a revolutionary influence on society, and the effects and changes in our fundamentals have only begun. Years ago buildings were built to last a life time, and the materials used had to stand lots of wear and tear. Today buildings are sometimes built to serve a single sales promotion program and tomorrow they will be outdated. The effect of all this means more to hospitals than we at first are willing to admit.

What Is Modernization?

We hear the word modernization on all sides of us. Just what does it mean as applied to the hospital?

We are all aware that the technique in every department of the hospital has changed greatly. The equipment and the tools with which hospital services are rendered have advanced and improved almost as rapidly as the metamorphosis of the automobile. As the automobile improved we recognized the problems of the road and took steps to solve them; we did not try to hold the automobile down to the limits of the old section line dirt roads. Yet, you can go into almost any city and find well run hospitals housed in 50-year-old buildings that have had only very minor changes made in them during the years of service.

This is not a build-up for a suggestion to discard all of our old buildings and build new ones. The old roads were not discarded; they were improved, bad turns were eliminated, traffic flow was studied, underpasses were put in, and gradually the old roads became the highways of today. Too little has been done to keep our hospitals in step with the advancements made in other lines of endeavor.

Hospital Problems of the Future

This would be a good omen and a place to anchor in these whirlwind days if there was any indication that society will become tired of speed and knowledge and settle back into the ways of our forefathers. The tendencies point, however, to a continuation of the present trend and there are many indications that there will be more changes in the direction of bettering the conditions of the masses. This means much to hospitals, and if they are not to be left by the roadside in this advancement, their directors must discard their smug attitude and look to the problems of the future.

Are we not going to have more and more group hospitalization, more and more health insurance, and perhaps some form of state control over all hospital and medical care? Is not the day when patients evaluate hospitals and make their own selections drawing to a close? Will not the hospital of the future get most of its business from its contacts with organized groups? Will not hospitals in the future render more and better care to patients "on the hoof"? Why must a person be put to bed before any service can be rendered? These and many more are the vital questions for the hospital executive of today, because the hospital with its years of tradition, prejudices and customs cannot quickly be changed over. It is a slow process of unfolding that will take years of careful direction and planning.

The hospital family must be allowed to first taste the new era, then sample it, and finally become a part of it all very gradually. This is well because it allows us to practice husbandry with our present facilities and to become equipped to meet the new conditions piecemeal.

The only problem is that there must be an imaginative mind directing each institution who can evoke a plan so that as each improvement is made it will fit into the ultimate plan. Hospital executives will have to do some daydreaming, correlate their ideas and compare notes with others in similar institutions.

More Ambulatory Patients

The day may come when every individual will be required to report to a health center for a periodic check-up and most of the minor of health problems. Why should it not be the hospital in the community? This means that considerably more space will have to be allotted to servicing the "ambulatory" patients; in fact, perhaps eventually the putting of patients to bed for care and treatment may be the smallest part of the total service rendered.

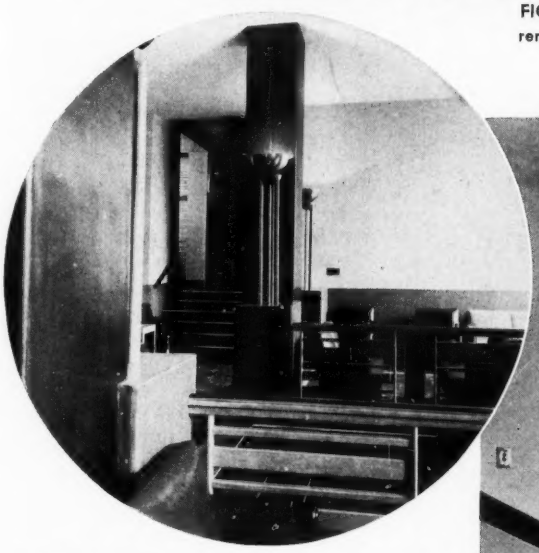
When this comes about, the auxiliary departments, like the X-ray, laboratory, therapy, etc., will have to be accessible, flexible and easily expanded. Imagine a large outpatient load, and visualize the probable traffic to and from all of these departments, the records and files involved, and the personnel required to render the service. It is very intriguing to say the least.

Perhaps the day will come when all babies must arrive via the hospital. What will this mean to the obstetrical department, and is the fundamental technique of your nursery adequate for all the problems of such a requirement?

Maybe our health centers will be required to demonstrate food preparation, at least for sick folks. Will

A great deal has been written about the construction of new hospitals, but little data has been made available about the modernization of old plants. Yet, in most instances, this is the plan which will have to be followed. Accordingly, HOSPITAL MANAGEMENT will publish, during 1940, a series of articles on the modernization of the hospital, its services and its facilities, each article dealing with one specific department. In this, the first of the series, Mr. Swern discusses the general aspects of any problem in modernization and suggests means whereby such plans can be made successful.

FIGURE 1. The lobby of the Lutheran Deaconess Hospital, Chicago, before it was remodeled.



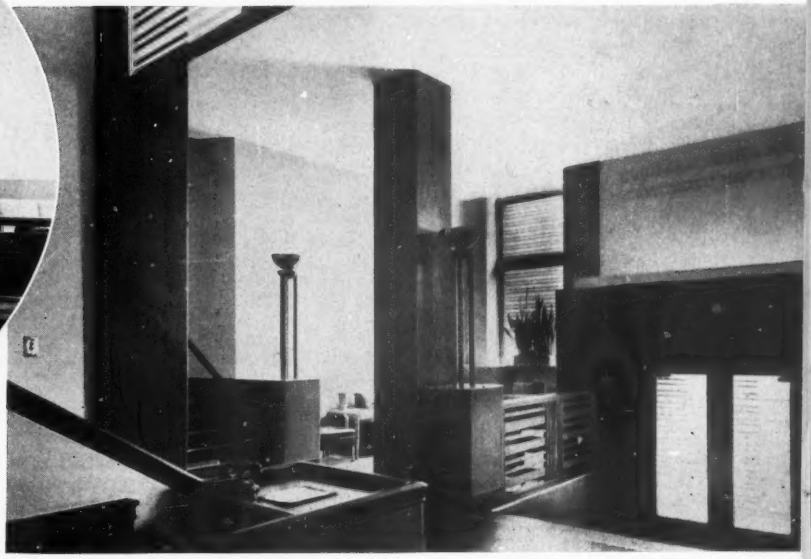
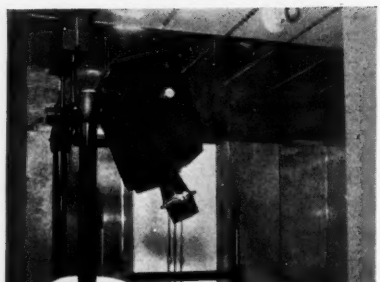


FIGURE 2 above, and FIGURE 3, right. Two views of the remodeled lobby of the Lutheran Deaconess Hospital. Old floors, walls and heavy plaster beams were removed and linoleum and mastic tile installed. The elimination of marble and terrazzo has softened the lobby and has given it a modern feeling.

FIGURE 4, below, and FIGURE 5, right, illustrate how the exterior of the Berlin Memorial Hospital was greatly changed by remodeling the entrance and cornice.



FIGURES 6 and 7. The interior of a room remodeled for deep therapy in the X-ray department of Lutheran Deaconess Hospital, Chicago.

your dietary department and its personnel be presentable and accessible for such a public contact?

With the advent of earlier contacts with the public, perhaps the number of very sick patients and the needs for major surgery will shrink. There are several hospitals now with oversized surgeries and operating rooms "to let."

In this increase in ambulatory patients, the tuberculous patients are going to present some problems. How will they be handled?

Unfortunately the greatest hazard of speed is an increase in accidents. This may be controlled some, but it is reasonable to expect that accident cases will continue. What will be the problems of this service, the "ins" and "outs," and quick contacts with the other auxiliary departments?

Visualize Needs

Take your imagination outside of the confines of your present "brick and mortar" and endeavor to visualize the kind of a building that will be needed to house the business of the hospital of the future. Then, after you have a clear picture of what you would like to have, start imagining what can be done to your present building to bring it in line with your ideal. Many compromises will have to be made but it is really remarkable how easily the old and new can be made to work together.

The real objective of all this is to stress the idea of looking ahead and thinking through the problem before any steps are taken, so that the changes made today will fit into those that will be made in the days to come. Most of our hospitals are like patchwork quilts; the various units have been added without an ultimate plan. Such a procedure creates much lost motion and space and lowers the possible efficiency of the hospital. It is better to have a plan, even if it is not all that it should be, than to have none at all.

Unfortunately the turnover in personnel in the executive end of our hospitals is great, and seldom does one executive stay through more than one expansion or remodeling program. We suggest that after you have crystallized your ideal, you spread a plat of it on the hospital records so that in the days to come your successor can see why such and such things were done. Placing a copy of your dream of the hospital in the future in the corner stone would be very interesting to posterity.

In the last 20 years many new materials, and methods of using old materials, have been developed for buildings. Some of them are shortcuts for old problems, but quite frequently they bring up new problems, so it is important to weigh them all in the light of the service required of them. Looking at our contemporary buildings, stores, apartments and even residences, it would seem that being modern means to use materials in an unusual way. This is really not the crux of modern construction.

The best of our modern construction is simply an envelope for a plan that has definite functional features. If the plan is right and the building is allowed to express it, you will obtain a building that seems modern even if all its details are old fashioned. That is why it is possible to modernize old buildings; the plan is the thing, and the materials used are only incidental.

The first impressions made on visitors and patients to a hospital are very important and the best place to get these impressions started favorably is right at the front door and in the public lobbies. Most commercial institutions are aware of the value of these first impressions and there has been almost an epidemic of remodeling, with the result that the public expects it. Hospitals with entrances that have not been touched for years are at a great disadvantage.

Figures 1, 2 and 3 illustrate an old lobby remodeled into the spirit of the times. Old cold floors, walls and heavy plaster beams on the ceilings were removed and the new materials of linoleum and mastic tiles were installed. This elimination of marble and terrazzo has softened up and quieted the lobby and gives a modern feeling that every one notices. Discarding old materials that are not worn out does seem hard to do, and in some cases it may not be necessary, but we do get tired of looking at the same thing year after year.

Figures 4 and 5 illustrate an old exterior greatly changed by remodeling the entrance and cornice of a building that was definitely dated by its architecture.

Figures 6 and 7 illustrate the interior of a room remodeled for deep therapy in the X-ray department. Sheet lead was applied to the back of ply wood panels, and the panels were held in place with stainless steel snap-on mouldings, all detailed to make a continuous sheet of lead on all walls and ceilings.

One of the departments in every hospital that is coming in for extensive revamping in the near future is the nursery. A technique that gives almost complete isolation in the care of each baby is just around the corner. Stuart K. Hummel of the Silver Cross Hospital, Joliet, Ill., has developed a basinette stand that incorporates a complete dressing table for each baby, so that all work in connection with each infant can be done with individual equipment.

Modernizing gives much material to talk about. The publicity about it quickens the tempo of public opinion and will keep institutions from falling into a rut and allowing others to capture their business.

To sum up: Let us first look into the future and see where we are going, then endeavor to lay out a plan that can be accomplished in pieces, attack the most vital piece and get started on a modernization program. The road is rough and the hazards are many. However, each step taken will strengthen the status of the institution.

Parenteral Fluids Need Not Be Warmed Before Administration

By E. W. ERIKSON
American Hospital Supply Corporation, Chicago, Ill.

The extensive use of both parenteral fluid and blood infusions continues to bring up the question as to whether these therapeutic agents should be heated to, or maintained, at body temperature during their injection into the circulatory system of the patient.

Several articles, especially previous to 1934, advocated body temperature maintenance of all volume injection of dilute parenteral solutions or citrated blood. Some of these detailed that, unless this was done, systemic reactions could be expected.

Thus guided, a great number of hospitals have installed warming cabinets for the storage of intravenous solutions. In many instances, cabinets were equipped with control devices so that the temperature could not exceed 108° F., and in other instances 112° F. Under these conditions it was presumed that during the administration to the patient the temperature of the solution entering the vein would be approximately that of the body of the patient, thereby hoping to prevent untoward reactions.

Other hospitals purchased water jackets for the purpose of warming fluids during dispensation, while a few purchased insulated electrically heated tubes in which the rubber tubing might be placed while the solution is being injected.

The use of hot water bottles strapped to the flask containing dextrose solution has been quite common practice in some sections of this country.

Reaction Due to Endogenous Byproducts

However, later investigations have shown that the factor largely responsible for "fluid reactions" is the presence of the endogenous by-products of two strains of organisms, namely pseudomonas ureae and pseudomonas scissa, in either the solutions or introduced in the preparation of the tube and needle sets used in fluid administration. The fact that these two organisms are universally present in surface water and have periods of maximum and minimum growth has been shown to be a major contributing factor towards the periodic appearance of untoward reactions resulting from the administration of parenteral fluid.

As a result of these studies, many persons began to wonder whether the dispensation of fluids at room temperature would actually produce untoward reactions in patients so long as the parenteral solution was not given at such a rate as to cause spillage into the urine.

Technique in Hospitals Investigated

Inasmuch as the author was interested in this subject, he made visits to many hospitals whose staff men demanded that fluids be warmed to the "proper temperature" before administration. These hospitals included those equipped with warming cabinets, as well as those that had improvisel blanket warmers for solution storage. It also included those hospitals equipped with water jacket flask holders in which staff men specified that the hot water used therein for warming the filled container be 115° F., 120° F., or 125° F., etc., etc. Strange as it may seem, these hospitals using jacket warmers or hot water bottles for this purpose never checked the temperature of the container after dispensation nor did they ever determine the temperature of the fluids immediately before the point of entry into the patient.

In some hospitals electrical heating devices surrounding dextrose filled containers during dispensation were thermostatically controlled—most of them were not.

With the experience secured in the field, it was decided to do actual laboratory studies and the problem was presented to the research department of one of the laboratories devoted exclusively to the manufacture of parenteral fluids.

Dispensing tube and needle sets, as commonly used by hospitals for intravenous and hypodermoclysis administration were selected and set up to approximate actual conditions as they exist in hospitals. During this investigation a sealed thermometer was placed just ahead of the needle so that the temperature of the fluids about to enter the vein could be accurately determined, and a carefully calibrated measuring device was used so that the speed of dispensation could be accurately determined, and in no instance were the various dextrose combinations given at a speed greater than the absorption or utilization rate of humans.

The resultant findings were very interesting. It was learned that all pre-heated or warmed containers, even when heated as high as 140° F., actually delivered their contents to the vein at room temperature, or only slightly above.

Such an observation could logically have been expected, for it is necessary for these fluids to traverse five or six feet of exposed rubber tubing between the container and the recipient, and it was only logical to expect that this length of tubing would serve to act as a heat exchanger, permitting equalization of the temperature of the fluids with that of the room.

In general, it was found that it is not possible to deliver fluids at body temperature, or even near body temperature, under practical conditions. It is necessary that the original temperature of the container and the rate of administration exceed both practical temperature and rate of administration in order to achieve the desired temperature at the needle. Therefore, it is our opinion that most solutions given in hospitals today actually enter the vein of the patient at approximately room temperature, or at best, just slightly above, no matter what type of heating cabinet or container-warmer is used.

With these interesting findings before us, we are now reasonably certain that by far the greater bulk of all solutions dispensed are at room temperature, and experience has shown that there are no reactions occasioned by the administration of py-

(*Continued on page* 34)

During the past year we have had many inquiries as to the necessity for warming parenteral solutions before administration and, since there was so great a difference of opinion from the clinical point of view, we asked Mr. Erikson to tell us of his experiences in calling upon a great number of institutions in this country and Canada. This article expresses his conclusions together with the results of an investigation which he was able to secure from the research department of a concern manufacturing intravenous solutions.

Hospitals Review Recent Progress In Anesthesia Service

Rapid progress in the organization of anesthesia departments in hospitals to take advantage of the many new and important agents developed for general anesthesia is reported by leading hospital administrators. Their views of what can be done further to improve the service in this important department are presented in this timely article.

Although the hundredth anniversary of the development of anesthesia in surgery is rapidly approaching, most authorities agree that the greatest advance in the development and administration of anesthetics has come about in the past fifteen years.

What have been the most significant developments from the standpoint of the hospital? What can hospital administrators do to insure the successful use of anesthetics from the standpoint of the surgeon and the patient? These are questions which many of our readers have been interested in discussing.

The following comments represent an interesting cross-section of hospital opinion regarding anesthesia, including the organization of the service, the administration of anesthetics and the safety factors which must be considered in view of the special character of many of the modern agents now in general use.

Selection of Agent Desirable

Dr. Joelle C. Hiebert, superintendent of the Central Maine General Hospital, Lewiston, Me., expresses the point of view of many experienced executives when he says:

"I believe the greatest development in recent years is the recognition of the desirability of selecting the anesthetic agent most suitable for the patient, and the administration of it by one capable of doing so with the greatest degree of safety.

"Wherever there is a hospital having three physicians or more on its staff," he continues, "one of those physicians should be an anesthetist, and all anesthesia administered should be given either by him or under his direction. When the administration of an anesthetic agent is regarded as a specialty and directed by a capable physician, the patient will have the advantage of safer anesthesia and the surgeon will be able to devote his primary attention to the surgical procedure."

The importance of selecting an anesthetic for individual patients is also stressed by Dr. B. W. Black, medical director of Alameda County Institutions, Oakland, Cal., who says:

"It would occur to us that the greatest development in anesthesia in recent years has been the use of a wider variety of anesthetics as they may develop and be used under competent medical supervision. This permits a better adaptation of the anesthetic to the patient.

"In order to accomplish this particular purpose, we have placed in charge of our anesthetic department, a physician who is trained in anesthesia. He is expected to keep abreast of anesthetics and new anesthetic methods, demonstrate them, by way of teaching, to the nurses, interns, and instruct the interns to give such anesthetics. He also advises the surgeon operating relative to the best anesthetic to give in the particular operation, having in mind the condition of the patient. To keep abreast of the entire field of anesthesia is a part of his responsibility, and to make such tests to assure the use of anesthetic in a modern, safe and efficient way as may be required.

"This, we think, meets the requirements of this institution and gives the best service to the patient as well as improvement in the service rendered to the surgeon who may be operating."

Definite Departments Established

The most far-reaching development, in the opinion of Dr. Allan Craig, superintendent and medical director of Eastern Maine General Hospital, Bangor, Me., has been the establishment of departments of anesthesia in hospitals and the placing of the responsibility for the administering of anesthesia in the hands of those especially trained in this particular work. "This," he comments, "has meant the establishment of special training courses for anesthetists and the development of more intricate and accurate equipment for the giving of anesthesia."

H. S. Barnes, superintendent of the Latter-Day Saints Hospital, Salt Lake City, Utah, likewise emphasizes the necessity for well trained anesthetists, when he says:

"Perhaps the greatest development in recent years has been the opportunity for obtaining special preparation and study in this specialized field. Schools in anesthesia have been established which provide an opportunity for post-graduate training in this specialty. The trained nurse or doctor of medicine needs special emphasis in this field the same as in other lines in their profession. New gases have been developed and new methods to administer them, which require special knowledge regarding the patient. New machines have also been provided which have increased the efficiency of anesthetics, but all these developments and improvements are not safe nor effective in untrained hands."

Need for Training Recognized

The tendency to concentrate the giving of anesthetics in the hands of a few well-qualified persons, in small hospitals at least, is the most important change which has come about in the field in recent years, according to Edgar Blake, superintendent of The Methodist Hospital, Gary, Ind. "This," he says, "seems so much better to me, both for the surgeon and the patient, than to call upon any doctor who happens to be handy to administer anesthetics."

Miriam G. Shupp, R. N., chief anesthetist of Strong Memorial Hospital, Rochester, N. Y., adds: "In my opinion, the greatest development is the increasing cognizance on the part of those most concerned in this branch of medical service that it is a specialty and as such requires special training and skill for everyone engaged in this service."

Miss Shupp also comments on the development of anesthetic agents: "It would be impossible," she remarks, "to state that there has been one outstanding development in anesthetics, as several new agents have come to take their place in the armamentarium of this specialty, each one contributing its share to safe, efficient and pleasant anesthesias. This arma-

mentarium now includes, through recent discoveries and developments, a wide range of agents from which may be chosen the one best suited to the needs of the surgeon and the patient, considering, from the patient's standpoint, psychology, pathology and the surgery that is to be done.

"Among these newer agents, we may name of the more recent ones cyclopropane, vinyl ether or vinethene, the intra-venous barbiturates, and those which are not as new, avertin, ethylene and caudal and spinal drugs.

"I would like to add that the scientist who gives us an anesthetic with the potency of ether, the non-explosibility of nitrous oxide, the easy and rapidity of induction of cyclopropane and the rapid recovery of nitrous oxide and cyclopropane will have given us the greatest development since Crawford Long first discovered the anesthetic properties of ether in 1846 and performed the first surgical operation under ether anesthesia."

Ethylene-Oxygen Anesthesia

One of the most interesting opinions on the development of anesthetic agents is furnished by Dr. A. C. Bachmeyer, director of the University of Chicago Clinics, Chicago, Ill., who says:

"It is generally recognized that the introduction and development of ethylene-oxygen anesthesia has been the greatest advance in the field of anesthetics since 1923. Drs. Lockhardt and Carter of the University of Chicago administered ethylene anesthesia before professional anesthetists and surgeons on March 11, 1923, and on March 14, 1923, Dr. Isabella Herb successfully administered it to a patient at Presbyterian Hospital, Chicago. Dr. A. D. Bevan was the surgeon at this operation. Since that time it has been administered innumerable times throughout the world and has been recognized as the safest of anesthetic agents.

"Certain unfortunate occurrences associated with the administration of ethylene anesthesia in the early days of its use directed attention to the hazards involved in the administration of general anesthetics with gaseous agents. While these hazards, with specific reference to ethylene, were emphasized, it was shown that similar hazards were involved when other agents were used and many unwarranted fears were aroused. Experience in recent months with some of the newer agents shows that they possess even a higher hazard than does ethylene or ether anesthesia. Safety measures must be given careful and serious consideration and proper procedures must be established in connection with the administration of all forms of the gaseous anesthesias.

"All of our present day gaseous anesthesias were made possible by the introduction by Dr. Edmund Andrews of the administration of oxygen with nitrous oxide for prolonged anesthesia, and the Forum of Anesthetists held in Missouri during the meeting of the A.M.A. on May 15, 1939, was a memorial session in honor of his work."

Increased Use of Oxygen

In the opinion of W. B. Draper of the University of Colorado School of Medicine and Hospitals, Denver, Colo., the greatest advance in anesthesia in recent years has been the greatly increased use of oxygen, both during the actual administration of the anesthetic and post-operatively. One beneficent, although indirect, result of the introduction of the closed system of anesthesia, he says, has been the necessarily increased use of oxygen.

According to Dr. B. Henry Mason, superintendent of Waterbury Hospital, Waterbury, Conn., more progress has been made in recent years in perfecting methods of administering anesthetics than in the discovery of new agents that are safer and more efficient, and also in the use of suitable and efficient preliminary medication and the use of the basal anesthetic in combination with the various gases.

Use of Avertin

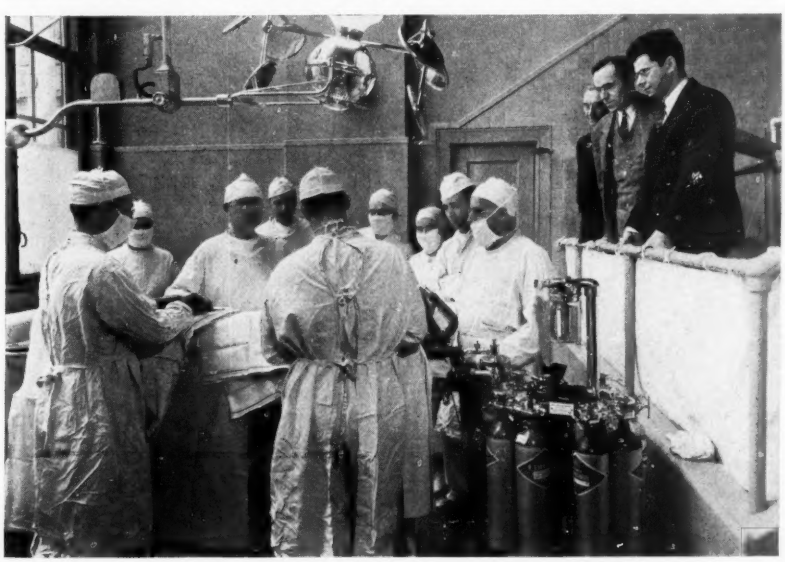
Dr. Norbert A. Wilhelm, superintendent of Peter Bent Brigham Hospital, Boston, Mass., writes:

"In my opinion, the greatest development in the field of anesthesia in recent years has been the use of avertin. My reason for stating this is that it brings the patient to the operating room with little or no emotional strain, that it aids in a smooth and easy anesthesia, whether that be gas or ether, and most important, it eliminates much of the usual post-operative discomfort.

"It is nothing short of dramatic," he continues, "to see patients who are nervous and apprehensive over their operations given avertin, fall into an almost natural sleep, and when they awaken, they are back in their rooms, the operation over, with no knowledge of ever having gone to the operating room."

Safeguards in Effect

The comments of those hospital administrators questioned by HOSPITAL MANAGEMENT indicate that in the majority of cases definite steps have been taken in order to assure safe and efficient administration of anesthetics. These steps include: the organization of definite departments of anesthesia, staffed by competent, well-trained individuals; the establishment of carefully kept records on all anesthesia cases: pre- and post-operative visits to patients by the anesthetist; regular meetings of the anesthesia staff and also participation by anesthetists in surgical staff and other meetings; the installation and use of modern apparatus; the adoption of new methods and types of anesthesia only after they have been proved safe and for the well-being of the patient, and the use of all recom-



The tendency to concentrate the administration of anesthetics in the hands of a few well-trained individuals is one of the steps taken by many hospitals in recent years to assure safe and efficient anesthesia. Photograph courtesy Augustana Hospital, Chicago, Ill.

mended safeguards against explosive hazards in the operating room.

At the University of Chicago Clinics, all anesthetists are physicians who are making this field their specialty. These physicians make pre-operative visits to every patient, examine his chart and personally make physical examinations when indicated. In conjunction with the surgeon, correct medication is chosen and ordered individually for each patient.

The anesthetic staff is trained to administer all types of acceptable anesthesia and these are given as indicated. Surgical interns are given a period of six weeks' training in the fundamentals of anesthesia. The choice of anesthesia is decided upon by consultation between the surgeon and anesthetist. Anesthetists are daily consulted by the surgeons in whose cases surgical procedures are contemplated in order that they might express their opinion as to the anesthetic management. The physician anesthetists indicate when shock therapy is necessary, give stimulants and suggest the advisability of intravenous fluids or blood transfusions. One anesthetist is constantly available for emergency administration of intravenous fluids in the operating room.

Post-Operative Visits Made

Anesthetists at the University of Chicago Clinics also make post-operative visits to each patient and complete the anesthetic record of the patient's course when the patient is discharged. All complications during or subsequent to anesthesia are discussed in the weekly meetings of the anesthetic staff. Studies of the final results covering each series of the various types of surgical procedures and anesthetic agents used are made by the anesthetists at regular intervals. New anesthetic agents are investigated in the laboratory by the anesthetists and a complete review of the literature is made before such agents are used on human patients. Weekly reviews of the current literature pertaining to anesthesia are given in the meetings of the anesthetic staff. Unsolved problems in anesthesia are investigated in the laboratories.

Members of the anesthetic staff also participate in the surgical staff meetings and other local meetings and take part in the various local, state and national organizations and programs. The anesthetic staff members participate in the didactic and practical instruction of junior medical students.

A similar program is carried out at the Central Maine General Hospital, Lewiston, which has established a de-

(*Continued on page 35*)

Hospital Topics to Be Featured at A. C. S. Sectional Meetings

Sectional meetings of the American College of Surgeons will be held at the Roosevelt Hotel, New Orleans, La., from Jan. 17 to 19; at The Biltmore, Los Angeles, Cal., from Jan. 29 to 31, and at the Hotel Statler, Detroit, Mich., from April 3 to 5. A hospital conference, which will include a series of talks, conferences and demonstrations, will be held in connection with each of the meetings.

Twelve states are included in the New Orleans meeting: Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, Kentucky, Missouri, Arkansas, Texas, Kansas and Oklahoma. Eight states are included in the Los Angeles meeting: California, Arizona, New Mexico, Utah, Nevada, Colorado, Oregon and Washington. Five states—Michigan, Indiana, Illinois, Wisconsin and Ohio, and the Province of Ontario—are included in the Detroit meeting.

The first session of the hospital conference program will be devoted to a panel discussion of the problems of the small hospital. Among the main aspects to be considered will be personnel, financing, medical staff, medical records, and nursing. Another panel discussion will be held on special services and problems of the hospital, and will include consideration of preparedness for emergencies; preparation, control, and technique in handling parenteral solutions; control of post-operative infections; group hospitalization on a state-wide basis, and proper clinical organization of the medical staff, with a list of additional problems to be discussed as time permits.

One session will be devoted to a conference on graduate training for surgery, and will include a report of a special survey of 400 hospitals by the American College of Surgeons for graduate training in general surgery and the surgical specialties. Another session will be devoted to a conference on care of the obstetrical patient, with the major headings of pre-natal care, admission of patient, the patient in labor, post-partum care, care of the newborn, and investigation and analysis of end-results.

In a general session, newer trends in professional services of the hospital, such as cancer clinics, fracture service, and standards for the care of obstetrical patients in the general hospital, will be discussed, in addition to such subjects as cooperation between the medical staff and management, the effect on the hospital of the trend toward medical and surgical specialization, medical records, nursing service of the future, and hospital standardization.

Hospital executives may submit, for presentation and discussion at a round table conference, problems which are of special concern to them. Also planned is a consultation round table conference which will afford opportunity for presentation of problems for discussion and possible solution, with an authority in each field of hospital work to discuss the problem submitted. Questions or problems may be sent to the American College of Surgeons, prior to the meeting, or they may be presented at the session, verbally or in writing.

There will be a showing of medical motion pictures of interest to hospital personnel, and many of the educational and scientific exhibits will also be of special interest to them. In New Orleans a study tour of the new $13,000,000 Charity Hospital is planned. In the other cities opportunity will also be afforded for visits to hospitals. The concluding session of all three meetings will be a meeting on conservation of health which will be open to the public.

Outstanding leaders in the hospital field will address the sessions of the hospital conference and will conduct the panel discussions and round table conferences. Hospital trustees, superintendents, nurses, departmental personnel and all others interested in hospitals are invited to attend.

Hospital Council to Study Accounting System

Rochester Hospital Council, Rochester, N. Y., has started a series of studies designed to assist hospitals of the city in their business operations and service to the public. The first study will be to determine the possibility of establishing a uniform accounting system for all hospitals.

The Council, recently incorporated, is composed of a representative of the board of trustees and the superintendent or medical director of St. Mary's, General, Genesee, Highland, Park Avenue and Strong Memorial hospitals. Managing director of the Council is Wilbur G. Woodams, an industrial consultant.

Who's Who in Hospitals

Appointment of GRAHAM L. DAVIS as consultant of the W. K. Kellogg Foundation rural hospital program in Michigan was announced last month by Dr. Stuart Pritchard, president of the Foundation. For the past 15 years, Mr. Davis has been assistant to Dr. W. S. Rankin, trustee of the Duke Endowment, Durham, N. C., and director of its Hospital and Orphans' Section.

Mr. Davis will be the consultant for all hospitals in Michigan that have a cooperative program with the Kellogg Foundation, and will also assist communities to make preparations for new cooperative projects.

S. CHESTER FAZIO, who has been superintendent of Rockaway Beach Hospital, Rockaway Beach, N. Y., since 1923, has resigned to accept the superintendency of the Easton Hospital, Easton, Pa., succeeding ALFORD R. HAZZARD, who recently resigned. MARY A. RYAN, acting superintendent of Rockaway Beach Hospital for the past eight years, has been appointed acting superintendent.

FRANK SELF has resigned as superintendent of the Fairview Hospital, Great Barrington, Mass., and has accepted a similar post at the Peekskill Hospital, Peekskill, N. Y., succeeding HANNAH LYONS, who resigned Jan. 1.

HARRY W. BENJAMIN, formerly associate superintendent of Mount Sinai Hospital, Philadelphia, Pa., has been appointed superintendent, succeeding FRANCES L. LOFTUS, R.N., resigned. JACOB PRAGER, M.D., formerly assistant director of the Jewish Hospital, Brooklyn, N. Y., has been appointed medical director of Mount Sinai.

A. J. LOMAS, M.D., superintendent of the University Hospital, Baltimore, Md., since 1923, has resigned to become administrative consultant for five Catholic hospitals—Mercy, St. Joseph's, St. Agnes' and Bon Secours, in Baltimore, and Allegheny Hospital, Cumberland, Md.

HAZEL MCIVER, R.N., has been named superintendent of the New London Hospital, New London, N. H., succeeding MARION WALLACE, who resigned recently.

MARGARET M. WATSON has been appointed superintendent of the Benedict Memorial Hospital, Ballston Spa, N. Y., succeeding MARIAN S. MACOMBER, who recently resigned.

LA VERNE BALZER, R.N., director of nursing at Queen of Angels Hospital, Los Angeles, Cal., has accepted the position of director of nursing at Ravenswood Hospital, Chicago, succeeding ALICE P. MAULL, who was forced to resign because of illness.

FRANCES DAVIDSON has been appointed superintendent of the new Magnolia Hospital, Little Rock, Ark.

L. D. FOWLER, Cincinnati insurance man, has been named executive vice-president in charge of operations of the Hospital Care Corporation of Cincinnati, succeeding LOUIS L. CLOW, who held the title of executive director.

A. E. WILCOX, M.D., has been appointed superintendent of the Minneapolis General Hospital, Minneapolis, Minn., succeeding D. W. POLLARD, M.D., who has been acting as superintendent for the past year.

HILDA HARDT, R.N., has been appointed superintendent of the Minnewaska Hospital, Starbuck, Minn., succeeding MYRTLE C. KVENVOLD, R.N.

L. R. WHEELER, formerly assistant director of the Rochester Hospital Service Corp., Rochester, N. Y., has been appointed director and executive secretary of Associated Hospital Service, Inc., Milwaukee, Wis.

RONALD B. MCINTOSH, M.D., clinical director at Norristown State Hospital, Norristown, Pa., has been elected superintendent of the Selinsgrove State Colony for Epileptics, Selinsgrove, Pa.

BROTHER ATHANASIUS SAVARY, R.N., director of the school of nursing of Alexian Brothers' Hospital, St. Louis, Mo., has been named administrator, succeeding BROTHER VULCAN, R.N. BROTHER WALTER, R.N., has been appointed director of the school of nursing.

JOHN A. PRITCHARD, M.D., superintendent of Buffalo State Hospital, Buffalo, N. Y., has been transferred to the superintendency of St. Lawrence State Hospital, Ogdensburg, succeeding PAUL G. TADDIKEN, retired.

RAYMOND F. C. KIEB, M.D., superintendent of the Matteawan State Hospital for the Criminal Insane, has been transferred to the Institution for Male Defective Delinquents at Napanoch, N. Y.

THERESA SWEETMAN, formerly of City Hospital, Nashville, Ind., has been appointed administrator of the W. S. Major Hospital, Shelbyville, Ind.

HELEN MAXWELL has been named superintendent of the Bluffton Community Hospital, Bluffton, Ohio, succeeding STELLA BURKHOLDER, who recently resigned.

CARL I. FLATH has resigned as superintendent of Wellesley Hospital, Toronto, to take over the assistant directorship of the Michigan Society for Group Hospitalization, Detroit, Michigan, effective January 1.

DENNISON YOUNG, M.D., has been appointed assistant director of The Jewish Hospital of Brooklyn, N. Y., to succeed JACOB PRAGER, M.D.

MILLICENT MAPES has been selected as superintendent of the Memorial Hospital of Green County, Catskill, N. Y., succeeding ALICE LEGALLAIS, resigned.

WILLIAM M. STOCKWELL, M.D., for 23 years superintendent and medical director of the Cedarcrest State Tuberculosis Sanatorium, Newington, Conn., has resigned.

WILLIAM MCQUEEN, M.D., formerly associated with the Marion County Tuberculosis Sanitarium, Indianapolis, Ind., has been appointed superintendent of the Sarasota Hospital, Sarasota, Fla.

REV. SISTER GAGNE, R.N., has been named superior of the Notre Dame de Lourdes Hospital, Manchester, N. H., succeeding REV. SISTER STE. FLORE, who has been transferred to St. Mary's Hospital, Lewiston, Me.

MOLLIE BOWMAN, R.N., for eight years superintendent of the Epworth Hospital, Liberal, Kan., has resigned that position. MRS. GERTRUDE C. ALLEN, R.N., a graduate of the Jewish Hospital School of Nursing, St. Louis, has been appointed her successor.

A radium worker at Westminster Hospital, London, watching the start of the boring of the well which will house the hospital's radium each night and in the event of an air raid.

London Hospital Buries Radium in Bomb-Proof Well

Fifty feet deep under the Thames gravel, a "safe-deposit" has been constructed for Westminster Hospital's radium supply—six grams of salts valued at between 150,000 and 200,000 pounds.

Fifty feet of steel tubing, 15 feet in diameter, has been sunk into the gravel. To reach this the three-foot thick cement raft upon which the hospital was built had to be cut away at the point where the tube enters the subsoil. An additional ten feet of tubing brings the mouth of the well to the level of the radium bomb room.

The work has been carried out so that it may be possible to bring back the hospital's radium from a similar "well" at the Royal Cancer Hospital where it was deposited at the outbreak of war. The radium bombs will be deposited in the tube each night and in the event of an air raid.

With the completion of the tube and the electrical apparatus for lowering the bombs into it, treatment by radium was resumed at Westminster Hospital. It will not be possible to carry on the work by night, but it is hoped to make effective use of both the bombs during daylight.

Winston-Salem Subscribes $222,000 in Hospital Campaign

As the result of an oversubscribed campaign for $200,000 to add a new wing to the North Carolina Baptist Hospital, the city of Winston-Salem, N. C., is now assured of a medical center.

In order to increase the hospital's capacity, the directors secured $30,000 in advance subscriptions toward the $200,000 needed and launched a public campaign to secure the balance. The campaign, directed by Ward, Wells and Dreshman, brought subscriptions of $192,000 to be added to the initial sum.

A gift from the Bowman Gray Foundation to Wake Forest College, making possible a new medical school adjoining the hospital, gave impetus to the movement to provide for the city's medical center.

Abbott Estate Announces $3,500,000 in Gifts

Gifts of $1,500,000 to Northwestern University and $1,000,000 to the University of Chicago from the estate of Clara A. Abbott, widow of the founder of Abbott Laboratories, were announced this month by the estate's trustees. The gift to the University of Chicago will operate to secure for that institution an additional $1,500,000 from the Rockefeller Foundation to be used for biological research, which was promised conditionally if the University secured an additional amount.

Other gifts announced by the trustees include $250,000 each to Victory Memorial Hospital, Waukegan, Ill., and Evanston Hospital, Evanston, Ill.

Ground Broken for Lebanon Hospital

Ground was broken Dec. 27 for the new 12-story, $4,000,000 Lebanon Hospital, Bronx, N. Y. The present hospital will be abandoned when the new building is completed.

Seven Directors Elected To Board of New York Plan

Seven additional directors have been elected to the board of Associated Hospital Service of New York, two representing hospitals and five, the medical profession. The board membership now numbers 18, divided into three categories, one to represent hospitals, one to represent the medical profession, and the third category to be subscribers.

Hospital administrators named as directors are Dr. Joe R. Clemmons, director of Roosevelt Hospital, and Dr. George S. O'Hanlon, medical director of Medical Center, Jersey City, N. J.

Gifts and Bequests Amount to $3,329,534

A total of $3,329,534 in gifts and bequests to hospitals has been reported to HOSPITAL MANAGEMENT during the past month. These include:

Clinton Hospital, Clinton, Mass., is the recipient of a $5,000 bequest under the will of the late Fannie R. Stevenson, which was recently filed for probate.

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A gift of $5,000 has been made to the Highland Park Hospital, Highland Park, Ill., by Mrs. Walter H. Baldwin and her sons in memory of their husband and father, Walter H. Baldwin, the first president of the hospital.

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Milford Hospital, Milford, Mass., has received a $50,000 bequest from the estate of the late Mrs. Meda Sparks Zimmerman. The money is to be used for an addition which is to be named the "Meda Sparks Hospital" in memory of the donor.

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Grove City Hospital, Grove City, Pa., is the recipient of a $1,000 gift, from the Kimberly Charity Fund, to be used for the purchase of new sterilizing equipment.

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According to the provisions of the will of Percy A. Chambers, the North Adams Hospital, North Adams,

Windows in the St. Stephen's Hospital, Fulham, England, are protected against air raids by being partially bricked up, leaving a narrow vertical slit which is glazed with glass bricks.

Mass., will receive a bequest of $5,000.

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Winchester Memorial Hospital, Winchester, Va., has been named under an insurance policy contract, held by the late Mrs. Georgette H. Bull in the Mutual Life Insurance Company of New York, and will participate to the extent of $13,534.55.

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Six hospitals will receive bequests from the estate of the late Henry Ware Putnam. The Henry W. Putnam Memorial Hospital, Bennington, Vt., will receive $3,000,000; Presbyterian, Mount Sinai, St. Luke's and the New York Post-Graduate hospitals, all of New York City, each will receive $50,000; a $25,000 bequest goes to Stuyvesant Square Hospital.

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According to the provisions of the will of the late Mrs. Elizabeth R. Fitch, Westmoreland, N. Y., Oneida City Hospital, Oneida, N. Y., will receive a bequest of $10,000, and St. Elizabeth and Faxton hospitals will each receive $5,000.

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The receipt of an anonymous gift of $5,000 by City Hospital, Columbus, Ga., to be used at the discretion of the hospital's board of control, was announced last month.

Broad Street Hospital Staff Reorganized

Completion of the reorganization of the staff of Broad Street Hospital and the Pan-American Clinic, New York City, was announced recently by the hospital's board of directors.

Walter H. Mende has been appointed superintendent. The directors elected Henry Lockhart, Jr., chairman of the board; W. M. Coverdale, president; P. C. Magnus, vice-president; John D. Reilly, treasurer; Mr. Mende, secretary, and Miss A. M. Burris, assistant secretary.

$500,000 Given to Greenwich Hospital

The board of trustees of Greenwich Hospital, Greenwich, Conn., recently announced the receipt of an anonymous gift of $500,000 to be used for the construction of a new building. The gift was made on the condition that the balance of the money needed, approximately $750,000, be raised, and that construction commence within a reasonably short time. Hugh D. Marshall, president of the board, has been authorized to appoint a finance committee to formulate plans for raising the balance of the funds needed.

THE HOSPITAL CALENDAR

Jan. 17-19. Sectional meeting, American College of Surgeons, the Roosevelt Hotel, New Orleans, La.

Jan. 29-31. Sectional meeting, American College of Surgeons, The Biltmore, Los Angeles, Cal.

Feb. 22-24. Texas Hospital Association, San Antonio, Tex.

March 6. Massachusetts Hospital Association, Hotel Statler, Boston, Mass.

March 8-10. New England Hospital Association, Hotel Statler, Boston, Mass.

March 27. Nebraska Hospital Assembly, Hotel Cornhusker, Lincoln, Nebr.

March 27. Mississippi State Hospital Association, Edgewater Gulf, Miss.

March 28-30. Southeastern Hospital Conference, Edgewater Gulf, Miss.

April 2-4. Ohio Hospital Association, Columbus, Ohio.

April 3-5. Sectional meeting, American College of Surgeons, Hotel Statler, Detroit, Mich.

April 4-6. Carolinas-Virginias Hospital Conference, Robert E. Lee Hotel, Winston-Salem, N. C.

April 8. Tennessee Hospital Association, Hotel Patten, Chattanooga, Tenn.

April 8-11. Association of Western Hospitals, Hotel Biltmore, Los Angeles, Cal.

April 8-11. Annual Meeting, Western Conference, Catholic Hospital Assn., Hotel Biltmore, Los Angeles, Cal.

April 11-12. Mid-West Hospital Association, Hotel Continental, Kansas City, Mo.

April 17. Alabama Hospital Association, Tutwiler Hotel, Birmingham, Ala.

April 22-24. Iowa Hospital Association, Hotel Fort Des Moines, Des Moines, Ia.

April 25-26. Kentucky Hospital Association, Brown Hotel, Louisville, Ky.

May. South Dakota Hospital Association, Sioux Falls, S. D.

May 16-17. Kansas State Hospital Association, Hotel Allis, Wichita, Kans.

May 1-3. Tri-State Hospital Assembly (Illinois, Indiana, Michigan, Wisconsin), Chicago, Ill.

May 8-10. Hospital Association of Pennsylvania, Pittsburgh, Pa.

May 12-18. Biennial Convention, American Nurses Association, Philadelphia, Pa.

May 18. Washington State Hospital Association, Spokane, Wash.

May 22-24. Hospital Association of the State of New York, Buffalo, N. Y.

June. Hospital Association of Nova Scotia and Prince Edward Island, Bridgewater, N. S.

June 6-8. New Jersey Hospital Association, Hotel Dennis, Atlantic City, N. J.

June 17-22. Catholic Hospital Association, St. Louis, Mo.

Aug. 11-13. National Hospital Association, Houston, Tex.

Sept. 16-20. American Hospital Association, Boston, Mass.

Oct. Ontario Hospital Association, Royal York Hotel, Toronto, Ont.

Oct. British Columbia Hospital Association, Empress Hotel, Victoria, B. C.

Oct. Vermont Hospital Association, Montpelier, Vt.

Nov. 13. Colorado Hospital Association, Denver, Colo.

Dec. 5. Utah State Hospital Association, Salt Lake City, Utah.

Minnesota Institute to Provide Valuable Refresher Course

The annual Minnesota Hospital Institute will be held Jan. 15 to 20 at the Center for Continuation Study, University of Minnesota, Minneapolis, conducted by the Minnesota Hospital Association in conjunction with the University of Minnesota and the American College of Hospital Administrators.

Chief aim of the program is to present subjects which will be of interest and value to the smaller hospitals. The course of lectures includes:

"Hospital Organization" and "Problems of Management," by James Hamilton, superintendent, New Haven Hospital, New Haven, Conn.

"Accounting" and "Rural Hospital Construction and Maintenance," by Graham L. Davis, director of Hospital Service, Kellogg Foundation, Grand Rapids, Mich.

"Inclusive Hospital Rates" and "Problems of Group Hospitalization," by John Mannix, director, Michigan Society for Group Hospitalization, Detroit, Mich.

"Public Relations" and "Writing for Publication," by Alden B. Mills, managing editor, The Modern Hospital, Chicago, Ill.

"State Group Hospital Plans," by Arthur M. Calvin, executive secretary, Minnesota Hospital Service Association.

"Personnel Problems," by Bertha Beecher, Christ Hospital, Cincinnati, Ohio.

This course of lectures, the demonstrations, round tables and conferences have been arranged to provide an intensive refresher course that will be valuable to any hospital administrator.

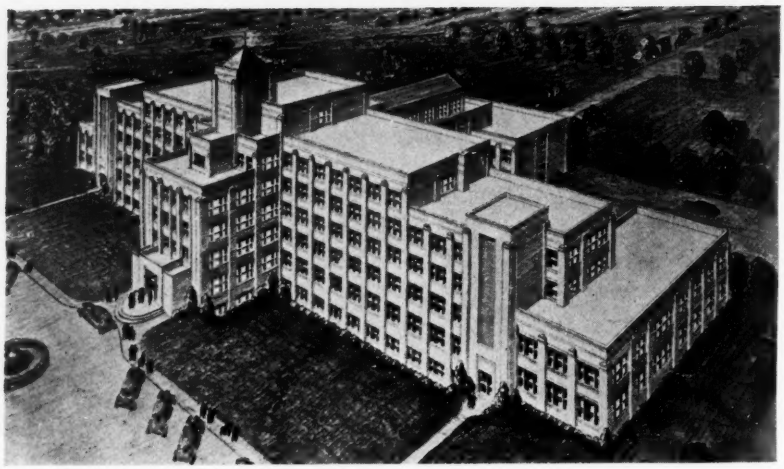
Knickerbocker Hospital Dedicates Memorial

The Knickerbocker Hospital held a reception Dec. 6 to dedicate the Eda W. Semken Memorial, donated to the hospital by Dr. George H. Semken, a prominent New York surgeon and a consultant on the Knickerbocker staff. Mayor Fiorello H. LaGuardia and A. Robert Munroe, president of the hospital, were among the speakers.

The memorial consists of the complete redecoration and refurnishing of the reception room and anteroom of the hospital's private pavilion.

Chicago Tumor Institute Gets $20,000 Bequest

Under the will of Spencer Penrose, who died in Colorado Springs, Colo., on Dec. 7, $20,000 is left to the Chicago Tumor Institute. The majority of the $16,000,000 estate was left to the El Pomar Foundation, a charitable foundation which will operate Mr. Penrose's interests.



The architect's sketch of the new 190-bed hospital, being constructed in Portland, Ore., by the Sisters of Charity of Providence.

St. Vincent's to Build 190-Bed Hospital in Portland

In a move which will bring the number of hospital beds in Portland to more than 3,000, the Sisters of Charity of Providence have contracted for the construction of a new 190-bed hospital in Oregon's biggest city. It is scheduled for completion late this year.

The new unit will house the departments of medicine, special medicine and pediatrics, and will operate as a division of St. Vincent's Hospital, which with 384 beds is Portland's largest. The present hospital is in the northwest section of the city, and the new hospital will be located across the Willamette river in the heart of the residential district of Portland's east side. It will be known as St. Vincent's Hospital, East.

The $1,000,000 building permit for the hospital, issued in Portland on November 30, was the largest permit granted in that city for ten years. The structure will be E-shaped, seven stories tall now but built on foundations capable of supporting a hospital of 500 beds in the future. Such expansion, which is contemplated, would call not only for increasing the number of stories, but for expanding of the ground plan.

Architect Francis B. Jacobberger, who designed the building, limited the largest wards to four beds—an arrangement described as a compromise between semi-private rooms and large wards.

The new hospital will have three surgeries but no maternity section or delivery room until an expansion program has been undertaken.

An unusual feature will be the absence of diet kitchens on each floor or intermediate floors. All serving will be done from the central kitchen, and food will be carried in warming carts on two special elevators. Dishes will be returned directly to the dishwashing department on a subveyor system.

There will be six elevators in the building—one for patients, one for visitors, one a utility lift, two for food service and one from the food storage department to the kitchen.

Occupying a 13-acre site, the building will have overall dimensions of 210 by 386 feet. The hospital chapel will seat 144 persons. Adjacent to the building will be grounds to accommodate automobile parking, and the balance of the property will be landscaped. The structural materials will be reinforced concrete faced with brick. Miles K. Cooper is the structural engineer, Jay H. Keller the mechanical engineer and Ross B. Hammond Co., Inc., the general contractor.

Sister Petronella, superintendent of St. Vincent's Hospital, will direct the operation of the new hospital. No staff appointments have been announced.

Postpone Enforcement of Purified Cotton Standards

The board of trustees of the U. S. Pharmacopœial Convention has announced that the enforcement of the U. S. P. standards for purified cotton (absorbent cotton), recently issued in the Second U. S. P. XI Supplement, will not be effective until July 1, 1940. This action has been taken in accordance with a recommendation of the U. S. P. Committee of Revision, the new standards for purified cotton requiring all official cotton to be sold in packages of not more than 1 lb., the product to be sterile and of at least a minimum fiber length. This has required such extensive changes in commercial practice that it will be difficult to meet the requirements before July 1.

Government Lends Radium To Thirteen Hospitals

Government-owned radium, weighing about two grams and valued at $50,000, will be lent to 13 hospitals within a few weeks, according to a recent announcement by the Public Health Service.

Consignments, all approved by the officials of the National Cancer Institute, will go to the Missouri Cancer Commission for use at the Ellis Fischel Hospital in Columbia, Mo.; El Paso City-County Hospital, El Paso, Tex.; Baylor University Hospital, Dallas, Tex.; Hillman Hospital, Birmingham, Ala.; St. Joseph's Infirmary, Louisville, Ky.; Robert Winship Clinic of Emory University, Emory, Ga.; Greenville General Hospital, Greenville, S. C.; Tri-County Hospital, Orangeburg, S. C.; Broadlawns General Hospital, Des Moines, Ia.; Indianapolis City Hospital, Indianapolis, Ind.; University of Pittsburgh, Pittsburgh, Pa.; New Britain General Hospital, New Britain, Conn., and the Receiving Hospital, Detroit, Mich.

The grants will be made in cooperation with state departments of health and state cancer commissions.

Dr. Stanley Reimann, director of the Lankenau Hospital Research Institute of Philadelphia, is shown here at the sixth annual Cancer Forum in Philadelphia with Mrs. Alfred Gray, president of the Women's Auxiliary of the Lankenau institute, and Mrs. Hilda Patrick, state chairman of Women's Clubs of Massachusetts.

International Harvester Adopts Hospital Plan

The Employees Benefit Association of the International Harvester Company has announced the adoption of a hospitalization plan under which employee-members will receive benefits of $4.50 a day, up to a maximum of 31 days, when confined in hospital. The plan became effective Jan. 1.

Under the plan an employee-member will contribute 12 cents a week, or 52 cents a month, depending on whether he is paid weekly or monthly, to a hospitalization fund. The Harvester Company will contribute to this fund an amount equal to 20 per cent of the total employee contributions. More than 47,000 employees will be eligible.

Benefits are payable to any employee-member who enters a licensed public or private hospital for treatment upon order of any licensed physician or surgeon. The plan is not limited to hospitals in the region where the employee lives. It covers any licensed American or Canadian hospital.

The benefit of $4.50 a day is limited to 31 days for any single disability. But if an employee-member should be hospitalized for another cause, he would again be entitled to receive $4.50 a day for a maximum of 31 days. In addition to the $4.50 daily benefit, employee-members will be reimbursed up to $30 in any one hospital confinement for operating room, anesthesia, X-ray, laboratory, or dressing charges incurred.

The plan does not cover payment of fees to physicians or surgeons, but applies only to hospitalization. The plan provides benefits for all illnesses or injuries, except those paid for under Workmen's Compensation Laws.

X-Ray Equipment Donated to Niagara Falls Hospital

P. G. Savage, superintendent of Niagara Falls Memorial Hospital, Niagara Falls, N. Y., has announced the receipt of a $23,000 donation from Charles Holland Moritz to be used for the modernization and enlargement of the hospital's X-ray department.

Correction

The article on the Illinois Masonic Hospital, in the December issue of HOSPITAL MANAGEMENT, contained the sentence: "The policy of the trustees, of which Judge Edgar A. Jonas is president, has been to administer the hospital as a business proposition and not as a charitable institution." This should have read: "The policy of the trustees, of which Judge Edgar A. Jonas is president, has been to administer the hospital as a charitable institution and not as a business proposition." The amount of contributions for 1938 was also erroneously reported as totaling $291,249, the correct figure being approximately $29,000.

New Rochelle Hospital Holds Open House

The New Rochelle Hospital held open house Jan. 6 and 7 in its new $600,000, eight-story addition, which will increase the hospital's capacity from 147 to 285 beds. Funds for construction of the addition were obtained through public contributions and a $275,000 mortgage.

Enlarge Facilities for Studying Blood Diseases

Dr. Harold W. Jones, director of the division of hematology at Jefferson Hospital, Philadelphia, announced this month that the hospital would soon have considerably enlarged facilities for studying diseases of the blood.

Some of these facilities have already been provided by a foundation in memory of the late Mrs. Charlotte Drake Martinez Cardeza. Her son, Thomas D. M. Cardeza, is a member of the hospital's board of trustees. The laboratories for clinical and experimental work and a department for biological photography have been set up and fully equipped at Jefferson Hospital by the foundation. Plans now are under way for a complete transfusion unit for clinical and experimental work in all phases of transfusion and intravenous medication.

Dr. Franklin R. Miller, who won attention at Western Reserve University for his researches in blood diseases, notably leukemia, has become associated with Jefferson Hospital as assistant director of the division of hematology.

Roosevelt Hospital to Widen Its Emergency Service

Funds to build and equip a new accident and emergency department, estimated to cost $125,000, are being sought by the Roosevelt Hospital, New York City, in connection with its proposed building development announced last Spring. Business concerns and corporations in the district bounded by 39th and 72nd Sts., Fifth Ave. and the Hudson River, will be asked to contribute. Charles G. Edwards is chairman of the committee of sponsors for the hospital's new facilities.

A recent study of 100 ambulance cases in New York City showed that immediate emergency treatment was sufficient in 53 cases, the patient must be removed to the hospital in 40 cases, the ambulance call is unnecessary in four cases, and the patient is dead in three cases.

Thomas Swift, representative of the American Red Cross, shown at the right, and Marquis de Lillers, president of the French Red Cross, talking with nurses as they visited a hospital established on one of the airdromes in the Paris district.

The Value and Control of Scrap, Surplus and Obsolete Materials

By HERMAN ZAAGMAN
Purchasing Agent, Butterworth Hospital, Grand Rapids, Mich.

One of the important functions of the purchasing department in any organization is to control and dispose of all scrap, surplus and obsolete materials.

The value of this function to the organization is too often overlooked, and in this article we will endeavor to outline some of the things that really can be accomplished by a concerted effort on the part of the purchasing agent or other responsibile executive.

There is no end to the number of items that can be salvaged by conscientious effort on the part of every member of an organization. No doubt the question arises as to whether the effort expended to control and dispose of this type material is really worth while.

With this in mind we thought it best to point out first the relative value of a few major items and list a few of the major groups into which this material can be divided, showing the relative value of each as salvage material. The following is a partial list of a general hospital, having an average daily census of about 150 patients, reporting the results of the first year:

Glass jars, bottles and jugs	$ 42.80
Wood and metal barrels	20.15
Scrap metal	16.92
Syringes	149.55
Electric lamps	61.22
Paper boxes	46.69
Paper, miscellaneous	72.60
Wood, tubs	1.60
Wood, crates	24.73
Wood, baskets	18.46
Garbage	275.00
Films, X-ray	87.57
Rubber	17.26
Silver (X-ray)	21.00
Bags (cotton and burlap)	9.86
Cans (paint, food, etc.)	12.84
Obsolete equipment	105.65
	$983.90

A number of the items classed as scrap or surplus may not be sold but can be transferred to other departments and put to good use. For example, we have in mind the use of steel alcohol drums as ash or garbage containers.

How are all the contacts for disposal made? What is the value of some of the items to be sold?

Scrap Paper

There is at least one season of the year when many temporary or obsolete forms are discarded. If clean and used only on one side, send them to your paper merchant or printer and have him cut and pad into scratch pads. This paper is worth more than 7c per pound in pad form. At present the market on newspapers is high and well worth the effort of systematic disposal.

Barrels

Wood. Laundry soap, soda, cleaning compounds, etc., are shipped in wooden barrels. In some cities there are dealers in barrels who buy all types at approximately 25c each. Wooden barrels may also be used for waste containers by applying a coat of paint and making a suitable cover.

Metal. Alcohol, liquid soap, wax, and glycerine often are shipped in metal drums. Many times these are charged on the invoice and can be returned for credit. If not, use them for garbage, ashes or rubbish. The average empty drum, when clean, is worth about 50c when sold to second hand barrel dealers.

Glass Jars, Bottles, Jugs

Many liquid foods, beverages and pharmaceuticals are packed in jars, bottles or jugs. First check whether they are returnable for credit. Pharmaceutical and laundry supply companies are usually anxious to buy these for refill.

Electric Light Bulbs

In some localities an extra discount is allowed on the purchase price of new lamps when a discarded lamp is returned with the order for new merchandise. This is true in our locality, effecting a saving of 15 per cent on almost all lamp purchases.

Pasteboard Boxes

Your local grocery or hardware jobber is usually willing to take these off your hands if in good condition. They pay up to 4c each for them.

Cotton and Burlap Bags

Use for dish cleaning or dish towels. If burlap, some cooks prefer this material for cleaning stoves. Dealers in bags buy used bags at approximately 2c each.

Wood Crates, Baskets and Boxes

Check whether your carpenter can use the wood or veneer from the wood boxes you receive. Sell orange and lettuce crates, lard tubs, bushel baskets and egg crates to farmers in your locality. Advertise in local newspapers for sources.

Garbage

Sell to farmer or packing house in your vicinity on bid and contract basis. Advertise in local newspapers for bidders. Be sure to have a clause in contract whereby all silver is returned.

Grease

Use the formula on the ordinary small can of lye for making soap. This can be used to best advantage in the kitchen for washing pots and pans. If there should be a surplus supply, sell it to your local packing house at the prevailing market price.

Bones

In some localities, packing houses have daily pick-up service to institutions for bones; ½c per pound is the usual market price.

Scrap Metal

Boiler grates, pipe, pieces of discarded equipment, aluminum and copper may be sold to your local junk dealer; get two or more bids if possible.

Syringes

Usually only one part of a syringe breaks. If this is the case, reputable syringe manufacturers allow approximately 33 per cent off on the purchase price of new syringes, when the old unbroken part is returned with the order.

X-Ray Films

Sell to highest bidder. Many firms manufacturing specialties such as menu holders, etc., are anxious to get this material and pay up to 20c per

(*Continued on page 35*)

This article is the eighth of the series on "More for the Hospital Dollar." Similar articles on other aspects of hospital purchasing will appear from time to time during 1940.

As the Editors See It

National Health Legislation

At a recent press conference President Roosevelt announced a modification of the health program initiated at the last session of Congress, and our Washington correspondent has given us further information on the probable trends of this legislation expected at the present session.

While the President's announcement was very vague and quite evidently had not been fully worked out, it is so great an improvement over the former program that it gives a ray of hope that sane and effective legislation will be ultimately adopted. This hope is further increased by the attitude of the sponsors of the Wagner bill and others who have been responsible for the proposals that have been made. Both Senator Wagner and Senator Murray have acknowledged that the former legislation needed revision and have taken steps to determine what form that revision should take.

Before the presentation of the report of the Interdepartmental Committee, we had become interested in the subject of hospital distribution in the United States and had started to make an analysis of the service available. This had just been commenced at the time of the announcement of the National Health Program and the later introduction of the Wagner bill, but it had gone far enough to convince us that the entire program, as visualized, was based on false premises insofar as it related to hospitals. We are, therefore, more than pleased to note the modification.

Our analysis of hospital service, which will be available in the near future, indicates that the statement that new hospitals are needed is both right and wrong, depending upon the interpretation. In our analysis we find that there are very few inhabited areas in the United States which are not within reasonable distance of a hospital of some type. Therefore, if the proponents of present legislation propose any extensive plan of building hospitals in entirely new areas we can see little justifiable excuse for such action.

On the other hand, there are many areas which are served by hospitals that are below standard and cannot render adequate service. Having visited a great many of these, we know that most of them are substandard because of unavoidable circumstances. It takes money to maintain a good hospital, but in many of the rural areas or those of a small urban population, money is not available. For this reason many small hospitals, particularly those of the privately owned type, are barely earning an existence, trying to give service but handicapped by the lack of necessary funds.

There are some small communities in which are located two or more small hospitals owned and operated by local physicians; in many of these, the community would be better served if the hospitals would unite. These hospitals are also attempting to give good service and some of them are succeeding, but the majority of the small hospitals, whether privately owned or not, need building up. In some communities it may be possible to utilize the buildings which are already available; in others it will be necessary to abandon these and build new. In this interpretation of the proposal for more hospitals we agree and see a definite need.

If such a program of replacement, rather than one of entering new fields, is undertaken, we are prepared to support it, provided it is free from too great a degree of political significance. Our observation of governmentally owned hospitals has led us to oppose them in most instances for the reason that it is so difficult to avoid that degree of political domination which submerges the good of the patient.

Our Washington correspondent appears to fear such complications at the present session of Congress, but we are still optimistic. We are not so naive as to hope that politics can be entirely eliminated from any legislative program, but we feel that the health of the nation is so important that there should be a minimum of political interference with any legislation that is justified by necessity. We believe that our legislators can reach an agreement without jeopardizing the lives and safety of people by the bartering and the trading which we are taught to believe is an inevitable part of the game of politics.

One very significant trend which is noted is that the organized medical profession is being called into conference. This is a move in the right direction, but it does not go far enough. Our legislators apparently are not aware of the fact that the average medical man and most of the medical leaders are concerned only with medical affairs and know little about hospitals. Strange as it may seem to some, they are woefully ignorant of matters which affect the hospital in which groups of their patients are treated. They take these for granted and look to the hospital profession to provide the necessary facilities. For this reason some of the leaders in the hospital field should be given equal prominence.

The entire question is of such far-reaching importance that it should receive very careful consideration. The health of the nation is good, but it can be improved. Since it is good, and since no person is suffering seriously, there is no emergency and time can be taken for thorough study. The mistakes that have been made in the study as it has been conducted to date have not been disastrous because they have led only to proposals. But the program is now at the stage where action may be expected. We urge that this action be very carefully considered lest it do more harm than good. If further delay is necessary, it would do less harm than improperly considered action.

HOSPITAL HIGHLIGHTS

20, 15 and 10 Years Ago

From HOSPITAL MANAGEMENT, January, 1920

Dr. C. D. Wilings becomes superintendent of Ohio Valley Memorial Hospital, Wheeling, W. Va.; Dr. Walter E. List resigns as assistant superintendent of the Cincinnati General Hospital, to become superintendent of Minneapolis City Hospitals, Minneapolis.

HOSPITAL MANAGEMENT urges federal government to include hospitals in general census of 1920.

Rensselaer County's new $325,000 institution for care of the tuberculous at Troy, N. Y., begins operations.

From HOSPITAL MANAGEMENT, January, 1925

Highlights of 1924 show progress of hospital field.

New York Court upholds right of Olean General Hospital, Olean, N. Y., to pick medical staff.

Dr. A. C. Bachmeyer, superintendent of Cincinnati General Hospital, Cincinnati, and president-elect of the American Hospital Association, elected dean of the medical school of the University of Cincinnati.

Dr. W. P. Morrill resigned as superintendent of Shreveport Charity Hospital, Shreveport, La., and is succeeded by Dr. J. M. Mosely. Dr. J. L. McElroy resigned as superintendent of Ancker Hospital, St. Paul, to accept the directorship of St. Mark's Hospital, New York City; Dr. Fred G. Carter, assistant to Dr. McElroy, is named superintendent of Ancker to fill the unexpired term.

From HOSPITAL MANAGEMENT, January, 1930

HOSPITAL MANAGEMENT starts publication of "How's Business?", a monthly feature to show business trends in the hospital field.

A.M.A. announces approval of 628 hospitals for intern training.

Dr. John G. William Greef appointed by Mayor Walker as hospital commissioner of New York City.

C. A. Lindblad, superintendent of Millard Fillmore Hospital, Buffalo, resigns to become superintendent of Homeopathic Hospital, Providence, R. I.

Planned Development of Hospital Facilities

A planned program of development is strongly recommended for individual hospitals. Yet it is rare to find in any community an attempt either to plan community hospital development for the future or even to coordinate the activities of the institutions available. Hospitals have just sprung up without conforming to any formulated policy, and as a consequence many of them are almost half empty.

The result is to be seen in most cities. Take Chicago as an example. According to the list of the American Medical Association, there are 78 hospitals in the city itself, having an aggregate capacity of 23,230 beds and an average occupancy in 1938 of 15,813. Only 68 per cent of the beds available were used; yet, to mention only a few examples, we constantly hear of the overcrowding of Cook County Hospital, of the lack of facilities for caring for communicable disease and of the utter absence of accommodation for the convalescent. A little planning and coordination of effort would undoubtedly save the city a lot of construction cost and would turn business to some of the hospitals which are half empty at the present time. Everyone would be benefited.

New York, through its hospital council, is attempting such a coordination of effort and planned development. Cooperation is voluntary but control is becoming effective. Here are some of the projects discussed and acted on in November.

1. Approval of reconstruction program of one hospital.
2. Recommendation that a hospital be closed.
3. Urging a merger between two hospitals.
4. Revision of a building program.
5. Consideration of additional hospital service for negro physicians.
6. Development of a summer children's hospital to a year around hospital.
7. Study of tax payment for the indigent in voluntary hospitals.

Can any person question the usefulness of such an organization, its effectiveness in securing adequate care for the sick and its influence in conserving the tax dollar?

We believe that if every city in the United States would follow some such plan of coordination there need be no cry of insufficient hospital facilities on the one hand and of hard times on the other.

Parenteral Fluids

(*Continued from page* 19)

rogen-free parenteral fluids using tube and needle sets which are certain to be free of pyrogenic substances.

In further consultation with the technical staff exclusively employed in testing parenteral fluids, another significant fact was called to our attention. In this laboratory 30 cc.'s of properly prepared parenteral fluids administered to a three pound rabbit in fifteen seconds would not cause any untoward reactions whatsoever. As a matter of fact, this is the practice in this laboratory, and consequently has been done thousands of times without ever encountering any indications of hyperpyrexia.

Again drawing upon our experience in calling upon a great many hospitals, we should like to point out a further observation that would seem to offer definite evidence that the temperature of the fluid entering the body of the patient has no bearing whatsoever on untoward hyperpyrexia reactions which are periodically encountered. The author makes particular reference to the practice of giving stored blood, either direct from the cold storage chamber or by merely allowing the blood to come to room temperature before administration, both of which are being done in many institutions operating blood banks as a means of administering blood.

In discussing this matter with the personnel in each of these institutions, they have been unanimous in stating that this practice is a sensible one and has never been responsible for any untoward results. We are also informed by personal communication of two instances in which cold blood was given at such a rate as to result in the arm of the recipient, from the elbow to the shoulder, being cold to the touch after the blood infusion was completed, and in each instance there were no untoward results.

In conclusion, it is our considered opinion that it is not necessary to warm fluids to body temperature before administration, for experience and research have shown that the administration of fluids or blood at room temperature or below is not responsible for untoward results in parenteral infusions. By far the greater majority of hyperpyrexia reactions are caused by the presence of the endogenous by-products of pseudomonas ureae and pseudomonas scissa, and that when due precautions are taken to avoid the presence of these organisms or their by-products, no typical hyperpyrexia reactions are encountered.

Progress in Anesthesia

(*Continued from page 22*)

partment of anesthesia under the supervision of a qualified anesthetist. Patients are examined before operation, and the anesthetic agent most suitable to the patient for the scheduled operation is chosen. The anesthetist also has charge of the preoperative and post-operative medication. This includes the administration of all gaseous therapeutic agents. The chief anesthetist also supervises all intravenous treatment, such as venoclysis and blood transfusions, and such other hypodermic medication as may be necessary.

Program at Strong Memorial

A six-point program is in effect at Strong Memorial Hospital, Rochester, N. Y., to safeguard the administration of anesthetics, according to Marion Shupp, chief anesthetist:

1. The hospital has for use the wide range of anesthetics now available to meet the needs of the individual patient and surgeon.

2. A well-trained staff of anesthetists who serve the hospital, the surgeons and obstetricians 24 hours a day and are available within ten minutes of call, thus assuring to the emergency surgical and obstetrical care at 3 a. m., and to the patient who may happen to be a non-pay patient, the same anesthesia service as that accorded the private patient whose operation has been known well in advance of the day it appears on the operation schedule.

3. By the installation and use of the newer gas apparatus (filter or rebreathing method so-called), thereby cutting the cost of gas anesthesia to a minimum, again making it possible to choose the anesthetic according to the patients' needs and not according to his ability to pay.

4. By the employment of a man in the maintenance department, a part of whose job it is to keep the anesthesia equipment in perfect condition, thereby assuring safe and efficient performance.

5. By carefully kept records, both from the clinical standpoint and the standpoint of all materials used in the department and comparative figures from month to month.

6. By having in effect in the operating room all the recommended safeguards against explosive hazards, i.e., spark proof electric switches, relative humidity of a certain degree, etc.

H. S. Barnes, of the Latter-Day Saints Hospital, also comments on the importance of guarding against explosions: "During the past two years, large sums of money have been expended in our institution for the construction of our new surgical division and hundreds of dollars specifically to insure safety in the operating rooms. Electrical outlets are explosion-proof and every precaution has been taken to meet the requirements of the National Board of Fire Underwriters. The public is entitled to the best in this and any other line, and a proper anesthetic means much to the post-operative patient."

Dr. B. Henry Mason adds: "When the surgical suite at the Waterbury Hospital was built some years ago, no provision was made to attempt to control static electricity in the operating rooms. For this reason, we do not employ ethylene and cyclopropane. In choosing the anesthetic agent, the surgeon and anesthetist must weigh carefully the requirements of the individual patient and the operative procedure, so that the end results will be smooth induction, safe maintenance always under control, speedy and uneventful recovery.

"Of late years, basal anesthetics have been found of great value in reducing or eliminating the apprehension and fear of the patient of the operating room. Avertin, evipal, nembutal, and sodium amytal are the ones in common use for this purpose in association with ether and nitrous oxide. Our gas machines are equipped with the circle filter carbon dioxide absorption apparatus, which results in a smoother anesthetic, less loss of body heat, moisture is maintained in the airways, fire hazard is reduced, and the cost of the anesthetic agent is greatly lessened."

Value of Scrap Materials

(*Continued from page 28*)

pound. There is some variation in price between the safety and acetate base films.

Atomizer and Irrigator Parts

A good grade of atomizer or irrigator can be taken apart and replacement parts purchased from the manufacturer at a reasonable cost.

Obsolete Equipment

Be salvage-conscious and use every opportunity in contacts with doctors, hospital executives, and other persons in the field to sell. Always, when buying new equipment, ask yourself the question, "Have I got anything to trade in?" Usually the best value can be obtained in this way. Advertise in journals.

The first item of concern to the executive in the control of salvage is to map plans so that all salvage and discarded equipment will be brought to one place and the sale or conversion supervised by a responsible person in his department.

Perhaps the ideal set-up is to have a central storeroom, an exchange system of issuance, adequate storage facilities and a good store clerk, under the supervision of the purchasing agent.

We have found that, psychologically, the most effective way of impressing the department heads with the importance of this function is to credit their supply account with the price received for material sold from their department and report to them regularly as to the amounts received for the goods returned by them. In many institutions some of the items mentioned above are given to the employees when requested. They ask for it because the material is of some value. In carrying out the plan outlined of establishing a set policy in regard to salvage material, the employee must be treated on an equal basis with other buyers of material.

A few days ago a florist asked us to save a number of number ten size tin cans and offered to pay us 2c each. He intended to cover them with decorative paper and use them for flower displays. Of course it takes time and valuable space to accomplish all this, but once the sources of disposal are established you will find, as we have, that the buyers will come to you.

The industrial field has always considered this phase of purchasing an important factor in effecting savings. Many have a separate department to carry out this function. It is important and should never be overlooked by any hospital executive regardless of how small the institution he directs may be.

Mid-West Pharmacists Meet at Lincoln, Neb.

The regular monthly meeting of the Mid-West Hospital Pharmacists Association was held Dec. 9 at the Student Union Building on the campus of the University of Nebraska at Lincoln.

The program, in charge of the faculty of the University's College of Pharmacy, included a discussion of the second supplement of the Pharmacopea of the U. S., by Dr. Joseph Bell Burt, and talks on the preparation of ampoule solutions by Paul J. Jannke, and on the responsibilities of the hospital pharmacist and the future of hospital pharmacy, by Dean R. A. Lyman.

The January meeting will be under the direction of the faculty of Creighton University, Omaha.

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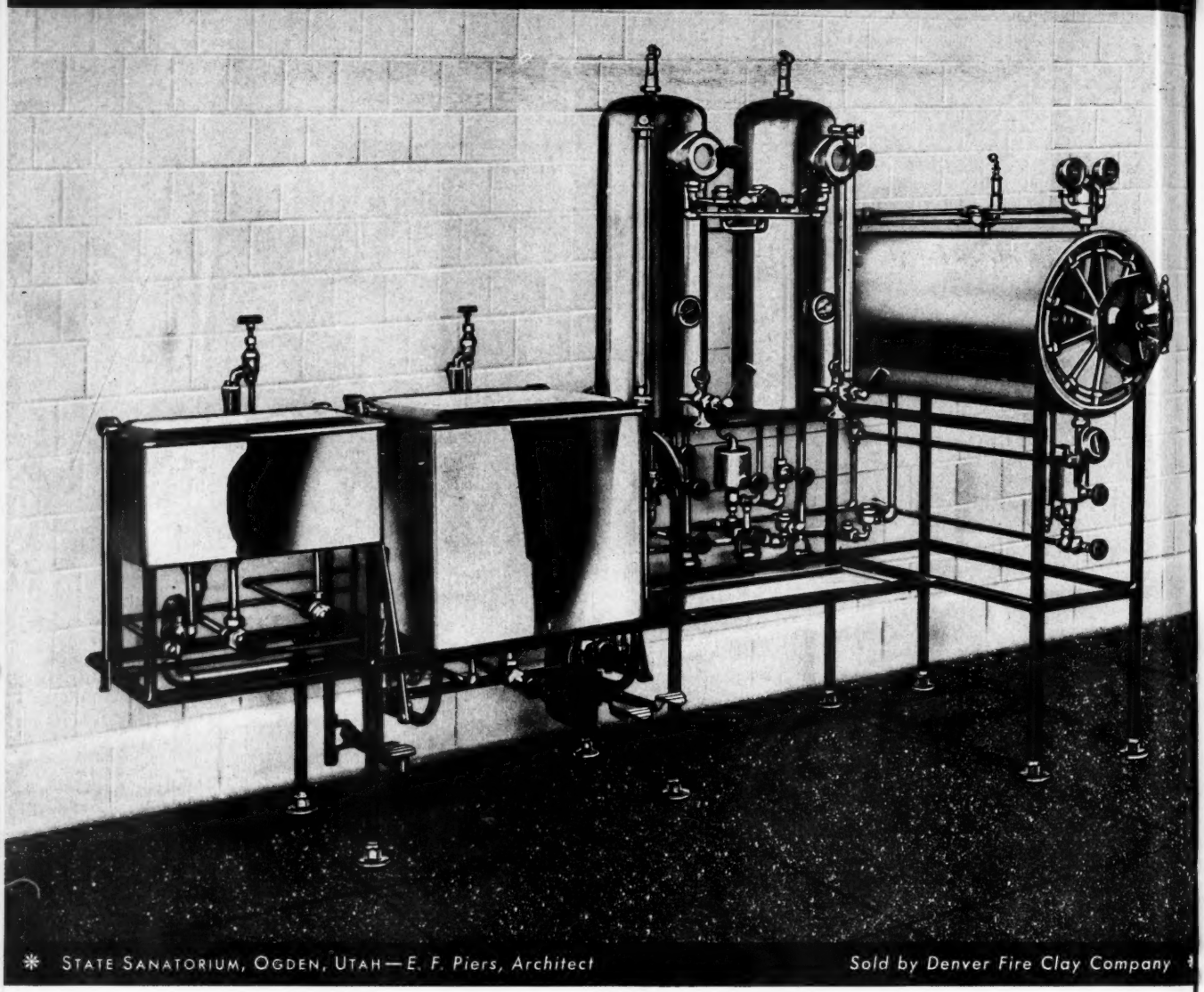

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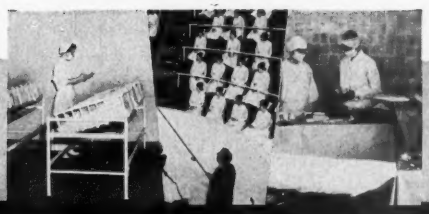

DEPARTMENT OF NURSING SERVICE

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Criteria for Efficient Graduate Nursing Service With Emphasis on Administrative Policies

By MRS. ALMA H. SCOTT, R.N.
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To the two key words in the title, "criteria" and "policies," I would add a third, the word "principle," for in my opinion a profound belief in the principle of providing good patient care—whether medical care, nursing care or patient care of any type—must inevitably precede the adoption of policies and criteria.

Whether we are conscious of it or not, every organization owes its inception to a principle. In a hospital, whose first purpose is to give care to the sick, the ethical principle underlying that purpose is that the care which patients receive shall be good care, namely, the best care that can be given.

Departmental Relationships

A second implication of the title is that the establishment of desirable departmental relationships is an essential factor in hospital operation. Nursing represents one department only in a dozen or more that constitute the hospital organism. If the policies of the hospital as a whole are predicated upon the principle of good patient care, then it is likely that the nursing department is safeguarded in the same manner. Also, it is obvious that any deviation from this principle in general hospital policies will be reflected correspondingly in the nursing department. In other words, good hospital nursing service cannot consistently exist in and of itself.

It may do so for a short period of time because of the weight of immediate personalities, but continuity in quality of service of any type demands stability and soundness of policies throughout the hospital organization.

In the further development of this article, I shall enumerate certain policies which are basic to sound administration, and shall assume that they exist in all departments of the hospital.

So that we may be thinking in the same terms, may I define a policy as nothing more or less than a plan for determining acceptable practices? General policies are established by the governing board; they then serve as references for the guidance of personnel. It is the responsibility of administrators to put policies into effect.

The Fundamental Policy

A highly important policy governing any institution is the policy of sound organization. This does not mean that all hospitals shall have the same type of organization. However, it emphatically asserts that there are certain basic organization principles which are fundamentally important, such as:

1. The existence of a direct line of authority and responsibility, reaching down from the chief executive of the hospital; and that there shall be delegation of authority commensurate with responsibility to departmental heads and to members of the hospital personnel.
2. The existence of official channels of communication and cooperation between the different departments of the hospital, as well as within each department.

The director of nursing service is immediately responsible to the hospital executive for the administration of her department. In turn, the hospital executive should delegate to her the authority essential for the satisfactory fulfillment of this responsibility. Through interviews, conferences and staff meetings, and by means of reports and memoranda, there is a mutual exchange of opinion and information.

Official channels of communication and cooperation exist both within the nursing department and between the nursing department and other related hospital units.

Additional Policies

Once the policy of sound organization is established, the adoption of further policies for the effective functioning of the organization are in order. These should include:

1. The policy of specifying the qualifications for central and departmental personnel, and of appointing personnel whose qualifications are in harmony with these requirements;
2. The policy of providing potential appointees with a clear statement of employment conditions;
3. The policy of delegating well-defined functions to employees;
4. The policy of providing sufficient personnel for safeguarding a good quality of service;
5. The policy of sponsoring a continuous program of staff education;
6. The policy of providing the proper working and living conditions for personnel;
7. The policy of maintaining an effective recording and accounting system;
8. The policy of using the budget

Presented before the Hospital Standardization Conference of the American College of Surgeons, Philadelphia, Pa., Oct., 1939.

system—not merely for a statement of estimated income and expense, but as a control or checking device on the quality of performance;

9. The policy of reviewing and studying the performance in all departments at regular intervals and of recommending changes which will result in more effective service;
10. The policy of maintaining proper community relationships.

Space does not allow the amplification of each of these suggested policies. As stated, they are generally inclusive in that they can be broken down into a number of "sub-policies." Thus, No. 7—"The policy of maintaining an effective recording and accounting system"—refers to patients' records, records of assignment of personnel and manuals in which duties of the personnel are listed, records involved in financial accounting, and so on through a whole series of records which are essential for a common understanding of work to be performed and which provide data upon which the development of the hospital service will depend.

Criteria and Their Use

With this brief discussion of administrative policies, let us now proceed to criteria and their use in hospital administration.

A criterion is simply a device for measuring the extent to which a policy has been put into effect. Merely to establish sound policies does not guarantee that sound practice automatically will follow. Some acceptable measure of policies must be adopted for the appraisal of their everyday use. Moreover, to be acceptable and to provide a reliable appraisal, criteria must have been evolved from the findings of studies conducted in a scientific manner.

In discussing criteria for an efficient graduate nursing service, I would like to recount briefly something of the criteria that have been evolved from studies made by the national nursing organizations. These may be used by hospitals to determine whether or not the policies listed heretofore are being put into practice.

The task of the nursing profession in this direction is by no means completed. Up to the present time, its work has been concerned with studies of the hospital in-patient service, so that the out-patient service is yet to be explored. Still, a beginning has been made and, while progress has been slow, it is believed that it has been sound.

Nursing Personnel

The three national nursing organizations believe that the effective functioning of any institution, especially one responsible for the care of the sick, is largely determined by the nature of the staff and conditions affecting the everyday working lives of staff members. Therefore, a great deal of thought has been given not only to the qualifications that should be sought in the nursing service personnel but also to those factors that enter into a reasonable and effective program of work.

As evidence, I would like to mention the *ANA Study of Incomes, Salaries and Employment Conditions Affecting Nurses,* and the *Manual of the Essentials of Good Hospital Nursing Service.* Also, may I call attention to the criteria which have been listed in "Hospital Organization and Management" by Malcolm T. MacEachern, M.D., associate director of the American College of Surgeons?

The result is a fairly compact group of criteria that can be applied with considerable objectivity. For example, criteria are now available to test the use of policies in reference to hospital organization and personnel. These criteria deal with various classifications of positions, such as: director or superintendent of the nursing service, assistant directors or superintendents (both day and night), supervisor, head nurse, general staff nurse and private duty nurse, and define the status of the positions of these persons and list the general qualifications which they should possess.

We have stated elsewhere that the director of nursing is responsible to the director of the hospital for nursing service in all of its detail. According to Dr. MacEachern—

> In order to properly fulfill her responsibilities she (the director of nursing) alone must have the authority and assume the responsibility for making the selection of the nursing staff. As a matter of courtesy and cooperation, she will consult with the director and possibly with the chiefs of service with regard to the selection of supervisors and head nurses, but the final decision as to employment and discharge must rest with her if she is to maintain that degree of authority which is so necessary for efficiency in the department.

In general, the selection of the nursing personnel should be based upon personal and professional qualifications of fitness for the position. Nurses should be chosen who are prepared by educational and cultural background, special training and experience to do the particular piece of work assigned. Nurses employed as general staff nurses or as private duty nurses in any hospital should be graduate registered nurses.

In making appointments, the previous professional record of the applicant should be considered and sufficient references kept on file to prove at any time, that due care was used in the selection of a given employee.[1] Special requirements for all members of the nursing staff should be listed on a well arranged and carefully thought out application blank, which also serves as a record for the hospital.[2]

Proper Supervision

It is essential that proper supervision be provided. Basic to a program of this type is an administrative group who are prepared to supervise and who possess ability to stimulate growth in their workers.

Good supervision should result in: (1) satisfying care to patients, both mental and physical; (2) creating initiative and improving the skill of the workers; (3) maintaining a staff who find satisfaction and happiness in their work; and (4) a reduction in the turnover of the personnel (extremely important in the effective operation of any organization).[1]

Interviewing Potential Appointees

The director of nursing service, or other qualified member of the nursing staff, should interview potential appointees to positions in the nursing department. This affords an opportunity to check the fitness of the applicant for a nursing position. The privilege of visiting the hospital on the occasion of the personal interview is appreciated also by the nurse.

At the time of the interview, a clear statement of employment conditions should be given to the nurse in order that she may be as fully informed as possible about her duties and responsibilities. This will give her a picture of the relative importance of her work to that of the department of nursing as a whole, as well as to the work of the hospital in general. Further, it will assist the nurse in adjusting to a new employment situation and will eliminate the possibility of misunderstandings arising later on.

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[1]Manual of the Essentials of Good Hospital Nursing Service, prepared by Division on Nursing of the Council of the American Hospital Association and a Committee of the National League of Nursing Education.

[2]Graduate Nurse Service—Some Practical Points for Consideration by Hospitals Contemplating the Use of Graduate Nurse Service—Committee on Distribution of Nursing Service of the American Nurses' Association (1933).

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Adequate Staff

While numbers of persons will not guarantee good nursing, it is certain that consistently good nursing cannot be maintained with an insufficient number of nurses. In an inadequately staffed situation, a breakdown inevitably occurs, both in the quality of care given to patients and in the morale and efficiency of the staff.

The National League of Nursing Education, through its Department of Studies, has carried on intensive studies of personnel requirements during the past eight years. Probably one of the most important outgrowths of these studies is that "ratios" are gradually disappearing from use as criteria for comparing the adequacy of the general staff group and that "bedside nursing hours per patient in 24 hours"[1] is the general accepted unit of measure for nursing.

The Manual of the Essentials of Good Hospital Nursing Service includes criteria for evaluating nursing staff adequacy. Some of these criteria will be revised in the light of the study *Administrative Cost Analysis for Nursing Service and Nursing Education.*

Staff Education

A number of objectives and principles basic to an effective staff education program are outlined in this Manual also and methods of developing such a program are described.[1]

A staff education program should be as comprehensive as the facilities of the institution will permit and should provide for active participation of all members of the staff.

Departmental conferences constitute a definite part of the staff education program. These should be held at least once a month and, if indicated, at more frequent intervals. All members of the nursing staff should be permitted and encouraged to take an active part. Opportunities for instruction and bedside clinics should be provided also.

A library, containing a wide range of standard text books, current nursing journals and publications in sufficient number to provide for supplementary reading, should be made available.

To be of assistance to nurses interested in graduate education in their clinical specialties, information should be placed on file regarding scholarships and loan funds and courses offered in colleges and universities and in other institutions.

Nursing Service Budgets

The extent to which nursing service budgets are utilized in hospitals, I am unprepared to say. It is generally understood that the use of such budgets has been limited.

PREMATURE STATION

This is the fifth of a series of photographs depicting phases of maternal and infant care as provided in representative Chicago hospitals.

Shown is the Hortense Schoen Joseph Premature Infant Station in the Sarah Morris unit of Michael Reese Hospital. The station consists of three rooms and a formula room. The special premature incubators used are heated and equipped for the administration of oxygen.

The Administrative Cost Analysis for Nursing Service and Nursing Education includes a chapter on the use of the budget and its relation to cost accounting. Principles and methods are discussed which may be reduced to a criterion system.

In the future, the budget may be considered not merely as a statement of estimated income and expense, but may be used as a control or checking device, to determine the quality of performance.

From a financial standpoint, if the director of nursing service is to administer the work of her department satisfactorily, it is necessary for her to be informed about the financial status of the hospital in general. and to have special knowledge and appreciation for those items which refer directly to her department. The director of nursing should be permitted to prepare the budget for the nursing department.

Employment Conditions

It is obvious that if personal and professional qualifications of staff members are to be carefully checked at the time of their employment, in order to insure that they will give good service, it is equally obvious that thought should be given to the working and living conditions which will be provided for them. There are no factors which will tend to modify the quality of nursing service to a greater degree than these.

For a number of years, the three national nursing organizations have been studying the relationship of working and living conditions to quality of service rendered by nursing personnel.

As a result of study, the American Nurses' Association has issued the following statements which are based upon the premise that, through their profession, all nurses should be able to attain economic security and provision for sickness and old age, to conserve their health, and to seek and attain mental stimulus in their work. These statements are that:

The hours of work represent a reasonable schedule—this implies an eight-hour day and a six-day week.

Unbroken periods of eight-hour duty, exclusive of time for meals, be considered as the desirable goal toward which institutions should be working.

Schedules of time off duty for institonal nurses be posted at least one week in advance.

A minimum of 28 days' vacation with pay be allowed to all members of the nursing staff at the end of a year of service.

One day vacation with pay for each two weeks of service be granted for those who have been employed for less than a year.

The hospital as employer give not less than 28 days' notice upon termination of a position.

The nurse as employee give not less than 28 days' notice upon resignation of her position.

Concerted effort be directed toward the adoption of more acceptable standards of employment for institutional nurses to the end that the well prepared nurse may become interested in this important type of nursing service.

The status of the general staff nurse in the hospital be clearly defined with special reference to her relationships to other members of the hospital nursing personnel.

Further, the American Nurses' Association has reached certain conclusions upon which are based the following recommendations:

That salaries for institutional nurses be commensurate with:
those of other professional workers in the community;
the duties and responsibilities called for by the position, and
the length of time for which the nurse is employed.

This policy should tend to reduce turnover and therefore costs for nursing service in a particular institution, and should create a more satisfied and efficient personnel.

That the monetary value of maintenance be emphasized by hospitals as being based on acceptable living conditions in the community. Where this is done, it is important that nurses recognize and realize the value of such maintenance.

That when nurses are employed on a daily basis they be paid at a relatively higher rate than when employed on a monthly or annual basis.

That a salary scale be worked out for the different types of nursing positions in institutions and established with due regard to the salaries approved for professional workers in the institutions.

Separate rooms (properly lighted, heated and ventilated), and an adequate supply of clean linen should be provided.

Health Program

In these days of economic stress, it is doubly important that the health of all workers be carefully checked. It is suggested that a yearly physical examination be required of all members of the hospital staff. In some instances, physical examinations are made available by a member of the medical staff of the hospital, at a minimum charge. Frequent physical examinations protect the employer as well as the employee. Preventable illnesses are expensive to the employer and employee because they are unnecessary. Therefore, it is important that the health program include a consideration of the vacation and illness allowance, the schedule of hours on duty, living conditions in general, and a yearly physical check-up of all employees.[2]

Community Relationships

Members of the hospital nursing staff must be conscious of the community implications of hospital service. In other words, they should be

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able to visualize the hospital as a scientific, civic and social center whose influence extends beyond hospital walls.

Every opportunity should be embraced to teach the principles of health to patients and to establish desirable relationships between the hospital and the community.

So far, I have confined this discussion to criteria affecting a graduate nursing staff and have endeavored to show their relationship to the general administrative policies of the hospital. Since subsidiary workers constitute a part of a well-organized hospital service, policies and criteria that relate directly to their use are essential.

The duties of non-professional workers should be outlined in written form and posted where they are readily accessible. The assignment of these persons should be safeguarded and qualified supervision should be provided.

A joint committee of the three national nursing organizations is studying this question at the present time and has outlined—

1. Activities of ward helpers and orderlies in hospitals, *and*
2. Suggested types of supervision and list of duties for subsidiary workers in nursing agencies.

Further, seventeen state nurses' associations are conducting state studies in an effort to secure as much data as possible relating to the use of these workers.

It is hoped to have a number of recommendations with regard to subsidiary workers to present to the board of directors of the three national nursing organizations for action in January, 1940.

State accredited schools of nursing are maintained in approximately 1,300 hospitals. In these hospitals, student nurses render service in the process of gaining experience. Therefore, it is important, both for good patient care and in justice to the students, that such hospitals set up educational policies of high standard and adopt criteria which are consistent with them.

In closing, it is reasserted that the quality of the nursing service in a given hospital will be determined largely by the administrative policies of that hospital. But the truth of the matter is that, while policies chart the course for hospital operation and criteria furnish the means for examining and re-examining that course, neither policies nor criteria guarantee good service. It is the way in which the findings (that result from the use of criteria) are "followed up" that affirms the integrity of a hospital as an institution to care for the sick.

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Changes in Nursing Personnel

RUTH CLEMENTS, assistant director of nursing service at Temple University, Philadelphia, has been appointed director of nursing service and principal of the school of nursing at Mountainside Hospital, Bloomfield, N. J.

MITTIE CATHCART, R.N., instructress of nurses at Danville State Hospital, Danville, Pa., has been appointed superintendent of the Philipsburg State Hospital, Philipsburg, Pa., succeeding ALMENA E. WUERTHMER, R.N., resigned.

MRS. MERLE W. JONES, R.N., superintendent of Kansas City Tuberculosis Hospital, Kansas City, Mo., for the past five years, has resigned to become superintendent of the new Artesia Memorial Hospital, Artesia, New Mex.

DOROTHEA VOLKERT has been appointed superintendent of Red Wing Hospital, Red Wing, Minn., succeeding RUTH MARTIN.

DIETARY AND FOOD SERVICE

MARY EDNA GOLDER
Dietitian, St. Anne's Hospital, Chicago, Ill.
EDITORIAL DIRECTOR

Controlling Costs in the Dietary Department

By MOIR P. TANNER
Superintendent, Children's Hospital, Buffalo, N. Y.

In the seventy-ninth annual report of the Buffalo General Hospital, a picture of the hospital operating dollar, as it averages among 90 hospitals, is set forth. Operating expenses, in order of size, are as follows:

Dietary Department	27.4c
Nursing Service and Education	15.3c
Heat, Light, Power, Buildings and Grounds	14.5c
Administration	10.9c
Housekeeping and Laundry	9.9c
Medical and Surgical Services	9.0c
Special Services	4.62c
X-ray Department	3.66c
Laboratory	2.8c

In other words, hospital food service accounts for 27.4c of every dollar expended by the hospital. This item is almost twice as much as any other single item in the budget.

In face of this fact it is not unreasonable that any superintendent should be most critical of the expenditures in this department and that every effort should be made to analyze costs with a view to reducing the operating expense of the dietary department, without reducing the standards of service.

Generally speaking, these dietary expenses line themselves up as follows: food, 65 per cent; labor, 35 per cent, and china, glass and silverware replacement, 5 per cent. Here again the two largest items each fall under the general head of controllable expense.

Labor Controllable in Planning

It is obvious that when the occupancy of the hospital is down, food purchases will be down, and conversely when the occupancy is high, food purchases will be up. It is not, however, true that the relationship of labor to occupancy is variable in like proportion, since there is certain work which must be performed if as few as 25 per cent of potential capacity of the beds are occupied. And, strange as it may seem, it requires almost as much labor to prepare 200 meals as to prepare 500.

Therefore, labor is controllable primarily in the planning of the food service department. If the vegetable room is located in a sub-basement, the meat refrigerators in another part of the basement, the dairy supplies in still another place, and the kitchen located on the main floor, it will require many man-hours per day to collect supplies from each of these various places and bring them to the kitchen. It is obvious, therefore, that it is desirable to have all store rooms adjacent to the preparation department wherever possible.

It is also necessary in laying out a food service department to have a flow from the raw product to the finished product in as nearly a straight line as possible

Often substantial savings are overlooked in the rush and confusion of new construction. Instead of the slogan "Keep the First Cost Down," the slogan should be, "Plan to Keep Operating Costs Down."

Institutional kitchen planning is frequently left until the moneys in the original construction budget have been earmarked for some other purpose. It is then necessary to equip with makeshift or "almost as good" equipment. Such an error is not only expensive from the operating point of view but often is never corrected.

Since food service is the greatest single item of expense in the operating budget, it is only reasonable to plan the food preparation departments with a maximum of production efficiency. The savings thus effected benefit the institution as long as this department is in use.

Sanitation an Essential

The first thought in the mind of the planning engineer should be sanitation. It is interesting to note that a kitchen which is designed to provide free flow, or straight line, production can be worked with the greatest efficiency and is also the easiest to keep clean and sanitary. For this reason the greatest care should be taken in the layout of the kitchen and in the selection of the equipment which will be the production machinery.

Every effort should be made to avoid the pitfalls of "price buying." Proper layout backed up with selected equipment can reduce the dietary food cost, kitchen labor, fuel cost and maintenance. Each of these items plays an important part in making up the total of 27.4 per cent of the operating budget for the hospital.

The food service department is the only department in the institution which has direct contact with the patient several times each day. This, again, stresses the importance of sanitation. Sanitation is not altogether a matter of strict supervision and rigid routine scrubbing and scouring, but is to a great extent the result of selecting proper equipment and placing it where it belongs in the general plan of the kitchen. Thus, such fixtures as sinks, tables, etc., constructed of seamless stainless steel or other non-corrosive metal, so designed that there are no square corners or right angle bends which are hard to keep clean, should be purchased. Radius corners and radial bends, welded and polished seams are standard construction with the better equipment manufacturers today. These manufacturers can also design sinks to hang from the wall. Where legs are required, they should be

round rather than angular, with bell feet.

The same care must be exercised in the selection of manufactured equipment, such as dishwashers, mixers, peelers, ranges, ovens, etc. In the selection of cooking and baking equipment it is desirable to give careful consideration to the time required for cleaning. Specialized appliances should be used, since their use not only increases efficiency of production but minimizes hard to clean range top surfaces and unsightly back-shelves.

Selection of Proper Equipment

Since approximately 30 per cent of the costs of the dietary department are in labor, each saving of labor is desirable. Five minutes saved on one operation a day amounts to many man-hours in the annual payroll; here truly "a penny saved is a penny earned."

Production equipment embraces everything that is used in the processing of food for service, and the cleaning up operations which follow service. The efficiency of production equipment has a direct bearing on production cost. The selection of proper equipment, therefore, has a direct bearing on operating efficiency and operating costs. It is impracticable to penalize production with "just as good" equipment, even though the initial saving may be several per cent.

Cheap equipment is expensive to own. It is better economy to buy the best equipment than to expend a first cost differential annually in maintenance and repair, and in the meantime lose some production efficiency.

The fuel cost does not play a major part in reaching a decision on what equipment to buy, because one piece of equipment could have cost a great deal more to operate and still be the less expensive to own. As one dietitian put it, "Fuel cost is such a small part of our operating expense that the difference between the cost of one fuel and another is negligible, but better working conditions and appliances which are easier to clean play an important part in helping us reduce labor and increase operating efficiency."

In institutional food service, fuel cost is a relatively small item. Yet only too often the selection of production equipment is predicated on fuel cost, rather than on the complete cost of production. For example, one hospital was prepared recently to increase its fuel cost two or three per cent in a change from gas to electricity. However, after the

(*Continued on page 49*)

When Cooking Beef

By INEZ SEARLES WILLSON
Director, Department of Home Economics, National Live Stock and Meat Board

Meat cookery research during the past 15 years has revealed facts which have out-moded many practices in meat cookery. As a result of this extensive research program carried on in the laboratories of the United States Department of Agriculture and the various state experiment stations, certain fundamental principles have been established which are applicable in cooking beef, veal, pork and lamb, but inherent characteristics of each may necessitate modification of method.

Beef cuts may be classed under two headings, (1) tender cuts and (2) less-tender cuts. The tender cuts are cooked by roasting, broiling and panbroiling; the less-tender, by braising, stewing and simmering. Regardless of the cut or the method, the cardinal rules in all meat cookery are to use a low temperature and avoid overcooking.

Cooking Time and Temperature

Shrinkage of meat during cooking is undesirable since appearance, palatability, nutritive value, and yield are adversely affected. Control of shrinkage is, therefore, of considerable importance to the dietitian who must estimate from the uncooked meat the number of servings and the nutritive value of each serving. Control of shrinkage is important, too, from the standpoint of costs, for excessive cooking losses increase operating costs.

Two of the factors which are known to influence shrinkage in meat are: (1) temperature and (2) cooking time. Shrinkage increases with increased temperature and cooking time.

Experiments in roasting beef have shown that total cooking losses increase in proportion to rise in oven temperature varying from 6.79 per cent in roasts cooked at 230°F., to 30.44 per cent in roasts cooked at 500° F. On the basis of servings, a seven-rib cut will yield six to eight more slices if cooked at a low temperature than it will if cooked at a high temperature. Beef roasts cooked to the well-done stage show more than 30 per cent increase in shrinkage over roasts cooked rare under the same conditions.

Fortunately, these two factors can be controlled by the cook. A constant oven temperature of 300° F. is used in roasting beef and the use of a meat thermometer is recommended as the best means of testing doneness, thus avoiding the shrinkage due to a high temperature and over-cooking.

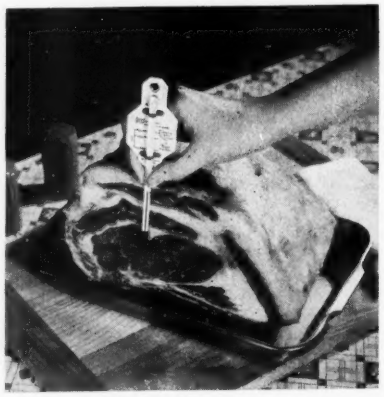
Other Advantages

The old notion that searing meat at a high temperature seals the surface and prevents the escape of juices has been proved a fallacy. It is a much simpler procedure to eliminate the searing period. A low roasting temperature makes the kitchen a cooler and pleasanter place to work.

A constant low temperature requires a longer cooking time than a constant high temperature, it is true, but the fuel consumption is actually less for the longer period. For example, beef ribs weighing 12¼ pounds required five hours when roasted at 250° F., but consumed only 63 cubic feet of gas, while a roast of the same weight roasted at 450° F. took three hours and consumed 95 cubic feet of gas. Incidentally, the former lost 1½ pounds in cooking and the latter lost four pounds.

Less watching and attention are required.

Since beef is served rare, medium, and well done, uniformity in cooking is especially important. One of the most striking effects of oven temperatures is shown in the appearance of the slice in medium or rare beef. When roasted at a high temperature, the slice, instead of being pink throughout, will have only a small circle of pink at the very center.



A meat thermometer removes the guesswork in telling when the roast is done, thus avoiding unnecessary shrinkage from overcooking.

with the remainder the characteristic gray color of well-done beef. With a low oven temperature, the slice will be uniformly pink throughout.

The same lack of uniformity results in broiling at a high temperature.

Not all of any roast can be sliced. The non-sliceable portion is more attractive, more usable, and there is more of it in roasts cooked at a low temperature. This is an economy factor not to be overlooked because the non-sliceable portion can be utilized to excellent advantage in the preparation of "made" dishes.

Flavor is more desirable and the roast is juicier when a low oven temperature is used.

Another advantage of a low temperature in roasting is that certain of the less-tender cuts, such as chuck, rump and round of good quality beef may be cooked by this method, thus adding to the number of cuts available for roasting.

Controlling Degree of Doneness

The practice of allowing so many minutes per pound for roasting is a far from satisfactory means of controlling doneness, because there are so many factors, other than time and temperature, which influence the rate of heat penetration. For this reason the use of the meat thermometer is advisable, because under normal conditions of cooking, when the temperature at the center of a beef roast is 140° F., the roast is rare; at 160° F. it is medium; and at 170° F. it is well done.

The temperature continues to rise after removal from the oven, if a rib roast is allowed to stand uncut. The rise is greatest in rare roasts and least in well-done roasts. This fact must be taken into consideration and roasts not to be carved soon should be removed from the oven at around 130° F., for medium rare. Experiments in roasting round-bone chuck roasts show that this rise in temperature seldom occurs and so it is not necessary to remove these from the oven before the desired degree of doneness is reached.

Do's and Don'ts in Beef Cookery

Do not waste meat and heat with excessive oven temperature.

Do not baste. It is a needless expenditure of energy. Place the roast in the pan with the fat side up and let it baste itself.

Do not add water to a roast.

Do not cover the pan, for a pot-roast will result.

Do use a thermometer to take the guesswork out of roasting.

Do not worry about when to add

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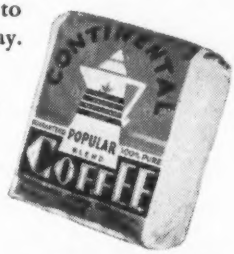

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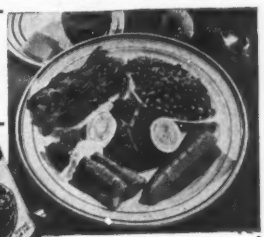

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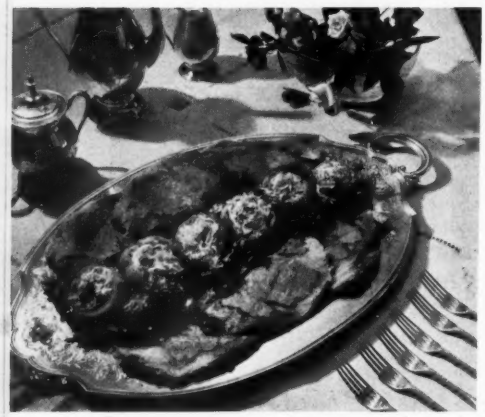

Sliced Cold Roast Beef with Stuffed Tomatoes (Buffet Set-Up)

Beef Birds

salt. It may be at the beginning or the end of cooking—and no great harm if omitted entirely.

Do not boil meat. A simmering temperature is best. This applies to stews, too.

Do use a constant low temperature for smokeless broiling.

Standing Rib Roast of Beef

2 or 3-rib roast
Salt and pepper

Season the rib roast with salt and pepper and place fat side up in an open roasting pan. No rack is necessary as the bones keep the meat out of the juices. Do not cover; do not add water. Insert a meat thermometer so that the bulb reaches the center of the largest muscle. Be careful that bulb does not rest on fat or bone. Put in a slow oven (300° F.) and roast until desired degree of doneness is reached. The thermometer will register 140° F. for a rare, 160° F. for a medium, and 170° F. for a well-done roast.

Allow eighteen to twenty minutes per pound for cooking a rare roast, twenty-two to twenty-five minutes per pound for a medium, and twenty-seven to thirty minutes per pound for a well-done roast.

Individual Meat Pies

2 pounds beef neck or shank
3 tablespoons flour
2 tablespoons lard
8 or 10 small onions
1 cup potato balls
1 cup peas
Salt and pepper
Biscuit dough

Have the beef neck or shank cut into 1-inch cubes. Dredge in flour and brown in hot lard. Cover with hot water, cover kettle tightly and let simmer two hours. During last forty-five minutes of cooking, add vegetables. When almost done, line individual baking dishes with biscuit dough. Fill with meat pie mixture and place in a hot oven until biscuits are done.

Beef Birds

2 pounds round steak, cut ¼ to ½ inch thick
2 tablespoons flour
2 tablespoons lard
2 cups bread or cracker crumbs
1 small onion, finely chopped
½ cup celery, chopped
1 egg, slightly beaten
Salt and pepper
Meat stock to moisten

Have round steak cut into individual servings about 2½ by 4 inches in size. Combine bread or cracker crumbs with onion and celery, and season with salt and pepper. Moisten with slightly beaten egg and meat stock. Pile a spoonful of bread dressing on each piece of meat, roll, and fasten the edge with toothpicks. Dredge with flour, brown in hot lard, add a very small amount of hot water, cover tightly and cook slowly until done, about one hour.

Editor's Note: What is your criteria of a well-balanced meal? Mine is well-prepared meat! Most chefs and cooks in the average hospital need constant coaching in the preparation of this particular food and so for this reason I have sought the assistance of Miss Willson in my campaign for better hospital food.

At the 1939 Stock Show in Chicago, Anne E. Boller of the National Live Stock and Meat Board arranged an outstanding exhibit of "low cost menus" which attracted much attention and caused considerable comment. Knowing that all dietitians are always on the lookout for new and inexpensive ideas, I hereby submit Anne Boller's beef recipe which appealed to me.—M. E. G.

California Chicken

¼ pound ground pork
1 pound ground veal
1 teaspoon salt
⅛ teaspoon pepper
1 tablespoon chopped green pepper
½ cup grated pineapple, drained

Combine all ingredients and shape like a chicken leg around a wooden skewer. Roll in bread crumbs, then in egg slightly beaten with 1 tablespoon water, and again in bread crumbs. Let stand 30 minutes in the refrigerator. Brown in hot fat, then reduce temperature. Cover closely, and cook slowly for 45 minutes. Mock chicken legs from the market may be prepared by this same method.

Chatterbox Topics

The November issue of the government's monthly magazine, "The Consumer's Guide," contains two instructive articles. One pertains to the making of margarine and the other to the topic, "America's Sugar Bowl." After you have read these articles, turn to the one about Boston drinking "surplus" milk.

•

The National Live Stock and Meat Board are distributing two new pamphlets. One, "Treasury of Meat Recipes," should be a welcome addition to your recipe collection. It's unusually well prepared, and I have tried many of the new recipes. The other pamphlet, "Meat Carving Made Easy," would be a grand publication for class distribution. While you are making your request for these two publications, ask also for the leaflet, "Meat from A to Z."

•

Do you crave new ideas for the patient who "grows thinner by the minute?" Try Cal-C-Tose instead of your routine milk drinks and combinations. My patients, especially those orthopedic cases who are weary of it all, relish this preparation when served with cookies or sandwiches. They wanted more, especially when I concocted a frosted drink or incorporated this product in an eggnog. The anemia cases look forward to this treat, too, and it has been a reward for taking the other "high iron" foods which they do tire of even though the foods have been dressed up.

•

In this day of stress upon full utilization of daily mineral and vitamin intake, we find a machine which assists in answering the problem of how to obtain fresh fruit and vegetable juices instead of over-working the can-openers. An electrical ma-

chine consisting of four simple parts, three parts of which are of stainless steel, has appeared on the market.

Serving fresh, unpeeled carrot juice, fresh pineapple or apple juices, fresh celery or spinach juices ceases to be a problem in the kitchens because the "spinner" in this new machine collects practically dry cellulose from the food and the juices pour forth strained and ready for use.

Institutional Food Index Down in November

November food prices decreased .43 per cent from the October price levels, according to R. M. Grinstead & Co. The November index at 107.27 was 3.91 per cent lower than the November, 1938, index at 111.63

The Grinstead Food Price Index is based on current prices paid by a selected list of institutions to purveyors and comprises prices actually paid for approximately 100 articles of food, weighted according to the proportion of these different foods purchased each month.

November meat price levels decreased 1.93 per cent from last month and were 12.65 per cent lower than November, 1938. Poultry prices for the month were 2.02 per cent less than those paid in October and were 3.99 per cent down from November a year ago. Seafood prices rose 1.26 per cent over those paid in October but declined 4.80 per cent compared with a year ago. Vegetable price levels continued to gain and were 2.10 per cent higher than a month ago and, compared to November 1938, they were 12.16 per cent higher. Salad prices increased slightly in the month but were 28.87 per cent lower than a year ago. Fruit prices dipped sharply.

Evaluating the weighted average of food prices paid in January, 1934, at 100, the course of price changes has been as follows:

January, 1934	100.00
November, 1938	111.63
December, 1938	112.07
January, 1939	110.52
February	111.35
March	111.54
April	111.34
May	109.54
June	109.47
July	108.58
August	106.57
September	109 88
October	107.73
November	107.27

The accompanying table shows in percentages the average change in November from the preceding month and from November, 1938.

Prices paid in November, 1939 compared to:

	October, 1939	November, 1938	November, 1939 Percentage of Expenditures
Meats (per cent)	— 1.93	—12.65	23.45
Poultry (per cent	— 2.02	— 3.99	9.98
Seafood (per cent)	+ 1.26	— 4.80	4.36
Vegetables (per cent)	+ 2.10	+12.16	6.93
Salads (per cent)	+ .21	—28.87	3.72
Fruit (per cent)	—11.87	— 4.18	3.37
Dairy (per cent)	+ .87	— 2.29	23.22
Groceries (per cent)	— .20	+ .86	24.97
Change on Total (weighted) (per cent)	— .43	— 3.91	100.00

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Day	Breakfast	Dinner	Supper
1.	Rhubarb; Cold Cereal; Bacon; Toast	Braised Liver; Baked Potato; Peas; Orange Prune Salad; Pineapple Tapioca	Fried Ham; Scalloped Potato; Waldorf Salad; Macaroon; Nut Cornstarch with Maple Syrup
2.	Grilled Grapefruit; Hot Cereal; Scrambled Eggs; Rolls	Broiled Trout; Mashed Potatoes; Brussel Sprouts; Lettuce Salad; Peach Meringue	Shrimp a la King; Asparagus; Baked Yam; Prune Whip; Spiced Cookies
3.	Tomato Juice; Hot Cereal; Poached Eggs; Toast	Roast Lamb; Browned Potatoes; Peas, Apricot-Cottage Cheese Salad; Chocolate Cake a la Mode	Bar-B-Q Beef Patties; Potato Chips; Slaw; Baked Apples; Raisin Cup Cake
4.	Orange Ambrosia; Cold Cereal; Bacon; Coffee Cake	Smothered Chix; Mashed Potatoes; Broccoli; Avocado-Grapefruit Salad; Date Torte	Cold Cuts; Candied Yam; Fruit Gelatin Salad; Ice Cream; Cocoanut Cake
5.	Grape Juice; Hot Cereal; Griddle Cakes; Syrup	Lamb Chop; Potato au Grautin; Glazed Carrots; Celery-Crabapples; Fresh Pineapple	Baked Ham; Baked Potato; Canned Tomatoes; Cranberry Refrigerator Pudding; Wafers
6.	Prunes; Hot Cereal; 3-Minute Egg; Sweet Rolls	Steak; Mashed Potatoes; Spinach; Spiced Peach Salad; Butterscotch Pudding	Split Pea Soup; Bacon and Fried Eggs; Tomato Salad; Fruit Cup; Cookies
7.	Applesauce; Cold Cereal; French Toast; Jam	Chix Pie; Riced Potatoes; String Beans; Tangerine Salad; Banana Split	Hot Corned Beef; Potato Salad; Celery-Pickles; Apricot Upside Down Cake
8.	Orange Juice; Hot Cereal; Bacon; Cinnamon Toast	Veal Loaf; Browned Potatoes; Cauliflower; Lettuce with 1,000 Island Dressing; Cottage Pudding with Chocolate Sauce	Creamed Tomato Soup; Fruit Salad Plate; Cottage Cheese; Biscuit; Jello; Cookies
9.	Apricots; Hot Cereal; Poached Egg; Toast	Baked Salmon Steak; Mashed Potatoes; Asparagus; Endive-Grapefruit Salad; Lemon Torte	Clam Chowder; Egg Salad; Baked Potato; Sliced Tomato; Olives; Strawberry and Rhubarb; Cake
10.	Pineapple Juice; Hot Cereal; Sausages; Muffins	Hawaiian Broiled Ham; Parslied Potatoes; Buttered Shredded Carrots; Relishes; Fruit Gelatin with Custard	Veal Chop; Scalloped Potatoes; Combination Vegetable Salad; Baked Apples with Maple Syrup
11.	Grapefruit; Cold Cereal; Bacon; Coffee Cake	Roast Chix; Mashed Yams; Peas; Lettuce and Roquefort Dressing; Steamed Fig Pudding	Toasted Cheese Sandwiches; Fresh Fruit Salad; Frosted Cal-C-Tose; Raisin Cookies
12.	Tomato Juice; Hot Cereal; Scrapple; Toast	Pork Tenderloin; Mashed Potatoes; String Beans; Log Cabin Salad; Patriotic Sundae	Jellied Ham Loaf; Spaghetti; Celery; Blueberry Cottage Pudding
13.	Sliced Oranges; Hot Cereal; Pancakes; Syrup	Roast Beef; Noodles; Harvard Beets; Prune Salad; Lemon-Strawberry Pudding	Chop Suey; Rice; Avo-di-Grapefruit Salad; Custard; Date Cookies
14.	Cinnamon Candy; Applesauce; Cold Cereal; Bacon; Toast	Fried Chix; Mashed Potatoes; Canned Tomatoes; Schircliffe's Heart Salad; Strawberry Ice Cream	Creamed Tomato Soup; Baked Potato; Molded Heart Salad; Red Jello; Heart Cookies
15.	Prunes; Hot Cereal; Poached Egg; Toast	Lamb Steaks; O'Brien Potatoes; Whole Kernel Corn; Tomato Salad; Sponge Cake with Lemon Sauce	Corned Beef Hash with Poached Egg; Spinach; Peach Salad; Junket
16.	Sliced Banana; Hot Cereal; Bacon; Muffins	Perch; French Fried Potatoes; Peas; Vegetable Salad; Apple Upside Down Cake	Scrambled Eggs with Grated Cheese; Spanish Rice; Orange-Prune Salad; Cup Cake
17.	Grapefruit; Hot Cereal; Bacon; Muffins	Veal Roast; Baked Potato; Creamed Carrots; Peach Salad; Chocolate Cornstarch	Hamburger Sandwich; Slaw; Tomato Juice; Green Gage Plums; Chocolate Cake
18.	Orange Juice; Hot Cereal; Bacon; Coffeecake	Roast Chicken, Parslied Potatoes; Wax Beans; Cranberry-Orange Salad; Blueberry Cobbler	Creamed Pea Soup; Chicken Salad; Potato Chips; Relishes; Butterscotch Sundae; Cookies
19.	Prunes; Hot Cereal; Pancakes; Syrup	Roast Beef; Mashed Potatoes; Squash; Lettuce Salad; Stuffed Baked Apples	Sausages; Browned Mashed Potatoes; Pear and Pineapple Salad; Eggnog; Ice Cream; Cookies
20.	Apricot Nectar; Hot Cereal; Scrambled Egg; Muffins	Baked Pork Chops; Baked Potato; Brussel Sprouts; Orange Salad; Raisin Rice Fluff Pudding	Bacon; Broiled Tomato; Watercress Salad; Fruit Dumplings
21.	Rhubarb; Hot Cereal; Bacon; Toast	Steak; Creamed Potatoes; Spinach; Fruit Gelatin Salad; Hot Gingerbread and Cheese	Beef Loaf; Candied Yams; Lettuce Salad with Anchovy Dressing; Banana Cornstarch Pudding
22.	Tomato Juice; Hot Cereal; 3-Minute Egg; Toast	Lamb Chops; Mashed Potatoes; Harvard Beets; Cinnamon Apple Ring Salad; Cherry-Marshmallow Whip	Egg Salad in Tomato Aspic; Baked Potato; Cherry Salad; Strawberry Ice Cream; Heart Cookies
23.	Orange Juice; Hot Cereal; French Toast; Syrup	Baked Trout; Potato-au-Gratin; Peas; Cucumber-Radish Salad; Butterscotch Torte	Peanut Butter and Cheese Sandwiches; Waldorf Salad; Cal-C-Tose; Cocoanut Bars
24.	Grapefruit; Hot Cereal; Bacon; Toast	Roast Veal; Scalloped Potatoes; Canned Tomatoes with Whole Kernel Corn; Relishes; Pumpkin Custard	Meat Balls; Spaghetti; Spring Salad; Raspberry Sherbet; Doughnut Balls
25.	Pineapple Juice; Hot Cereal; Bacon; Coffeecake	Fricassee Chix; Dumplings; Broccoli; Mixed Fruit Salad; Chocolate Sundae	Cold Cuts; Assorted Cheese; Potato Salad; Peas and Carrots; Fresh Fruit Compote; Sponge Cake
26.	Applesauce; Cold Cereal; Sausage; Toast	Baked Ham; Baked Yam; Creamed White Turnip; Avocado Salad; Strawberry Short Cake	Swiss Steak; French Fried Potatoes; Tomato Salad; Jello with Soft Custard; Cookies
27.	Prunes; Hot Cereal; Bacon; Biscuits	Roast Beef; Browned Potatoes; Cauliflower; Lettuce with Chiffonade Dressing; Applesauce	Meat Patties with Mushrooms; Rice; Cranberry Salad; Grapes; Spice Cake
28.	Tomato Juice; Cold Cereal; Sausage; Rolls	Fried Chix, Parslied Potatoes; String Beans; Stuffed Celery and Olives; Steamed Prune Pudding	Corned Beef; Stuffed Potato; Combination Vegetable Salad; Cream Puffs
29.	Grapefruit Juice; Cold Cereal; Pancakes; Syrup	Steak, Candied Yams; Asparagus; Pineapple-Banana Salad; Graham Cracker Torte	Veal Chops; Sauted Apples; Lettuce with 1,000 Island Dressing; Strawberry Ice Cream; Cookies

When Cooking Beef

(*Continued from page* 44)

installation was made it was found that the fuel cost was reduced rather than increased and that food cost was reduced from approximately 60 to 54 per cent.

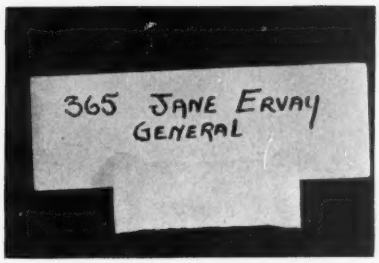
Inefficiencies in application, improper selection of fuel and poor equipment can affect the total cost of the dietary department as much as 15 per cent.

Today, much of the bulk cooking is done with steam. In many places "steam has to be available all year around"; yet, often where radiation losses from the transmission lines are taken into consideration, it is much more economical to generate the steam electrically and apply it to the cooking operation than it is to pay the continuous 24 hour a day radiation losses to do the same cooking operation with steam from the central plant. In a recent installation it was conclusively proved that it was more economical to operate an electric steamer than it would have been to operate the same steamer with 30c per thousand pounds steam.

Finally, it is not possible to overemphasize the fact that savings in first cost of equipment are almost invariably false economy, frequently penalizing production operation and maintenance. The best equipment is the least expensive to own.

As a guide to buyers, here are a few suggestions:

1. Buy only equipment made by well established manufacturers.
2. Determine production efficiency and adaptability before price.
3. Determine frequency at which service is to be required and the effect this will have on production.
4. Be sure service parts and labor are readily available at low cost.



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On holiday occasions, we sometimes put a menu or suitable favor in this holder, which lends a festive air to the tray. Ordinarily, we use plain colored cards, the color indicating the type of diet.

Submitted by Ruby Coury Patterson, assistant dietitian, Dallas City-County Hospital System, Dallas, Tex.

Book Shelf Addition

TREATMENT BY DIET, by Clifford J. Barborka, M.D. J. P. Lippincott Co., Philadelphia, Pa. Fourth edition, 673 pages; $5.00.

This practical paragon of references has again been revised. A few of the features which prompted me to pause and which were not dealt with so instructively in the previous edition were those pertaining to vitamins (especially K), methods of diagnostic aid in determining vitamin deficiency, and vitamin requirements of man. Pneumonia and fever diets are inserted as well as diets for treatment of Addison's Disease. I was grateful for the discussion of important dietary treatment of Hyperinsulinemia and last but not least the preparation and cooking of vegetables and meats to reduce the potassium content.—M. E. G.

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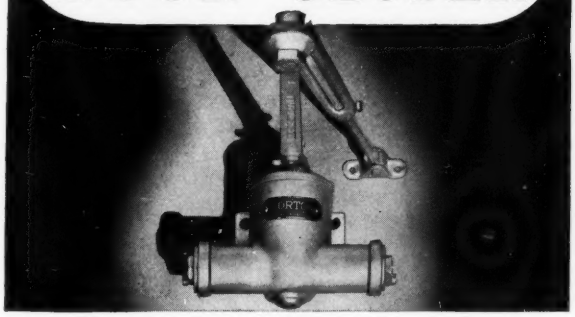

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CONTRIBUTING EDITORS

Hospital Power Plants Need a Doctor!

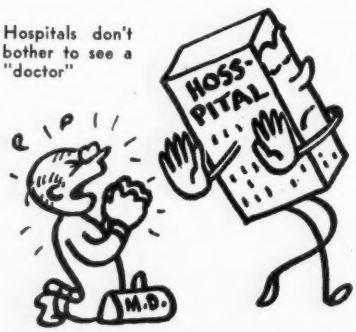
By PHIL SWAIN
Editor of "Power"

I have been asked whether hospital managers take their power-plant problems seriously. My answer is that they take these problems "seriously,", but not intelligently.

When it comes to engineering sickness, hospitals generally don't bother to see the doctor (that is, the competent engineering consultant). And where they do, they frequently fail to follow his advice, pleading lack of funds. To put this bluntly, the hospital is too poor to afford to cure its mechanical ills. Yet, it is poor because it has not taken the cure.

Some time ago I seriously considered making a survey of the actual mechanical set-up in several hundred hospitals. The questionnaires were about ready to mail out when a good friend, a hospital engineer, warned me in no uncertain terms to "lay off."

Come to think about it, a typical hospital power-survey return, if it could be obtained, would necessarily read something like this: Yearly heating cost—"don't know." Cost of steam per 1,000 lb.—"don't know." Steam consumed in laundries per 1,000 lb. of wash — don't know."



Hospitals don't bother to see a "doctor"

Boiler evaporation per pound of fuel oil—"don't know" . . . and so on.

As I see it, the basic causes for wastefulness in most hospital power-service organizations are three:

First is a financial set-up that makes it difficult to obtain money for any items whose usefulness is not obvious to the medical profession, the donating public, and the potential patients—even where the proposed expenditure would definitely benefit all three groups.

For example, Mrs. Jones endows a bed in loving memory of her departed husband. You never hear of her endowing a zone control for the heating system, or an evaporative condenser for the refrigerating plant, yet such an investment might cost Mrs. Jones less in actual cash, and, in truth, constitute a bigger medical service to the community, because the saving from the mechanical installation might pay for the operation of two or three beds.

The second basic cause of waste is the common failure to work a thoroughly trained engineer into the picture in a position of real authority, and to pay the market value of such a man.

The third reason is that most hospitals have a completely inadequate power-cost system, and also refuse to install the meters that would make possible an intelligent cost system.

Hospitals are innocently wasting millions of dollars every year by pooling heat, light and power costs allocating the total to departments on some fixed basis. The loss does not lie in the faulty allocation itself,

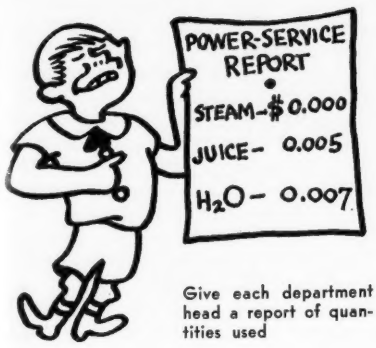
Mrs. Jones endows a bed in loving memory of her departed husband

but in the failure to change the allocation month by month as actual consumption changes. The system of charging power costs on a fixed percentage basis neither spots the dollar leaks nor gives department heads any real incentive to find and correct them.

Without a doubt, the first step in cutting power-service costs in any hospital is to put in some meters. What meters? The answer is to start with those that will make the biggest showing for the smallest investment. I would suggest one or more of the following: laundry hot water, laundry cold water, feedwater to boiler, oil fuel to boiler.

If possible, divide the institution into several segregated "departments," perhaps by buildings or by management groups. Always treat the laundry as a separate department. Then, as far as practicable, arrange to meter, separately to each department, the cold water, hot water, electricity, and steam (for heating and other purposes).

Assign a unit cost to each service (where possible, the actual unit cost, of course):



Give each department head a report of quantities used

1. Electricity at so many cents per kwhr.
2. Cold water at so much per 1,000 gal.
3. Hot water at so much per 1,000 gal.
4. Steam at so much per 1,000 lb.

Then give each department head, each month, a report of the quantities used and their total cost. If you do this, or even a halfway job of it, I can guarantee that the effect on your total cost will be astounding. For the first time it will become possible for a department manager to get personal credit for real savings he makes. This knowledge, and this incentive, may easily cut power-service costs in the laundry alone as much as 40 per cent in a single year.

In the same way, steam waste through careless operation of heating systems will be cut down everywhere, as department heads aim to make a better showing on their books. Overheated rooms will be cooled otherwise than by opening windows. Unneeded lights will be switched off. Consumption of every power service will go down in all departments. It is quite possible that the aggregate of these savings for the whole hospital will pay for all the meters within the first year—certainly within the first two years.

In most hospitals the big steam wasters are the heating system and the laundry. Both should have attention by experts in these fields. The heating expert is likely to recommend a vacuum system. By reducing steam pressure below atmospheric, more moderate radiator temperatures are available for mild weather, with resulting greater comfort and avoidance of the annoyance and waste of opening windows to cool overheated rooms.

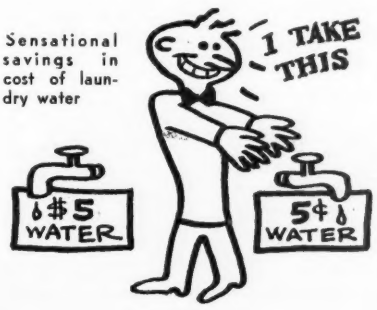
Another widely used modern device for saving heating steam is "zone control" Heat required in different parts of a building depends on exposure to sun, direction of wind and other variable factors. By dividing a building into zones, and controlling each separately according to weather conditions, no part is over or underheated and much steam is saved. I recently visited a hospital where steam savings from zone control are yielding a yearly return of 60 per cent on the investment.

I have seen sensational examples of saving in the cost of laundry water through better equipment and operation. Every hospital laundry should install not less than two water meters, one for hot and one for cold water. The laundry manager should receive each month a statement of the hot and cold water used, with the unit cost and total cost of each. These figures should then be reduced to the basis of consumption and cost per pound of wash, so that the operator will not be improperly credited for savings or blamed for a loss actually caused by a variation in the amount of laundry handled.

To be consistent, a meter should also be installed to measure the direct supply of steam to the laundry (other than that supplied in the form of heated water). However, steam meters cost considerably more than water meters, and I would not suggest delaying installation of water meters until money can be obtained for the steam meter. Half a loaf is better than none.

Very often an old or badly arranged refrigerating plant is a great waster of power and water, particularly the latter. Sometimes city water is used directly for condensing the refrigerant and then discharged to the sewer. This is very wasteful. An evaporative condenser or cooling tower will eliminate most of this water waste.

Next is the plant personnel. A good hospital engineer must be versatile and cooperative, as well as technically competent and experienced. He must have common sense and ingenuity. A sympathetic and cooperative attitude on his part makes mechanical knowledge contribute to medical service without infringing on



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But where will I get the money?

the doctor's prerogatives. Likewise, the medical men, generally hospital supervisors, and directors would do well to utilize the expert knowledge of the engineer.

If the hospital is small, it may be difficult, with the funds available, to obtain an engineer with practical qualifications plus technical training. Here it may be advisable to retain a consulting engineer or engineering firm on an annual fee basis to survey the plant and operations at intervals and suggest savings. Where a community has several small hospitals, they may band together to engage such service.

But when all is said and done, I find the big question is always this: "Where will we get the money?" This is particularly true of hospitals.

Suppose we meet this objection on its own level with a constructive proposal: "All right, let's take last year's actual expenditure for heat, light and power as the budget for the next few years. Also, let's depart from orthodox business procedure by including capital expenditures as part of the operating budget."

Under this set-up, a smart engineer or superintendent can go places. The first year he starts by making some obvious service savings. These pull his operating costs under the budget and he uses the difference, perhaps only a few hundred dollars, to buy a few essential meters. Their installation immediately creates further saving, permitting the purchase of more meters or other saving devices.

The effect is cumulative. Each thing put in creates savings that go on year after year. In this way it is possible practically to build a new plant without asking for a penny of appropriation or incurring any future liability. What board of governors could object to that—particularly since the result, after a few years, will be a cut of 20 to 50 per cent in power service operating expense?

Reprinted from December, 1939, issue of "Power." Illustrations courtesy "Power."

Room Disinfection

By F. JANE GRAVES
Superintendent, Alton Memorial Hospital, Alton, Ill.

The disinfection of a room that has been occupied by a communicable disease patient is done by a nurse or nurse aide under the direct supervision of the head nurse or floor supervisor. The equipment necessary for cleaning and disinfecting should be collected before the work is started. If there is no bathtub adjacent to the room, the equipment should include a large basin in which linens and blankets are soaked before being sent to the laundry in order to prevent stains from setting.

When the stains have been removed, the linen is gathered into a mesh bag and placed in a clean canvas or heavy muslin laundry bag, brought to the door of the room by a floor nurse. Care should be taken not to contaminate the outside of the canvas bag before it reaches the laundry. The linen is washed at 170° F. for 15 minutes. Blankets are placed in separate bags and sterilized with steam at 15 pound pressure for 20 minutes at 200° F., then laundered with the regular woolens. This will prevent the blankets from shrinking. If the hospital does not possess a mattress sterilizer, mattresses and pillows should be exposed to the sun for 24 hours, care being taken to see that the sun's rays reach all parts evenly. This is accomplished by repeated turning.

All enamelware, rubber goods and dishes are lysolized. Enamelware is then put in a pan sterilizer and sterilized for 30 minutes. Dishes are boiled in a weak lysol or other antiseptic solution for 30 minutes for final sterilization. Bed pans and urinals are placed in the bed pan sterilizer.

Furniture, floors and walls are washed with soap and water, and the room allowed to air for 24 hours before being made up for the next patient.

"Interior Decoration"

INTERIOR DECORATION, A Practical Handbook for Hotels, by Kathleen Carroll. American Hotel Association, 221 W. 57th St., New York, N. Y. 58 pp.; $1.00.

Although this booklet was published specifically for hotels, its contents will also be of especial interest and value to hospital housekeepers.

No attempt has been made to cover the entire subject of institutional interior decoration in this pamphlet. Rather, it is intended as a guide to point the right direction and avoid many of the pitfalls. The basic rules of interior decoration are stated, and the attention of the reader is called to the various products on the market, both new and old, as well as many new and more efficient ways of using the familiar materials. For those who wish to go further into the subject or into any particular phase of it, a list of references is included.

Chapter headings include "Color," "Floor Coverings," "Wall Covering," "Textiles," "Lighting and Lighting Fixtures," "Furniture," "Furniture Arrangement," and "Odds and Ends." The booklet is well indexed and has many marginal notes and illustrations. Also included are a number of blank pages for additional notes.

New Anesthetist At Reading

E. Atwood Jacobs, superintendent of Reading Hospital, Reading, Pa., has announced the appointment of Dr. Nevin H. Rupp to the newly created position of chief of the anesthesia service. Dr. Rupp was formerly associated with the Flower-Fifth Avenue Hospital, New York City.

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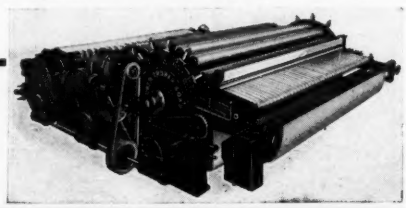

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PHARMACY, LABORATORIES AND SPECIAL DEPARTMENTS

Study of Dakin Solutions from 52 Hospitals Reveals Wide Variations

By FRANZ C. SCHMELKES, Ph.D.

During the World War when the need for an effective irrigating solution for contaminated wounds became very urgent, a sodium hypochlorite solution of definite concentration and particularly distinguished by its low pH was developed by Dakin and collaborators. Its application to the treatment of contaminated wounds was developed particularly by Carrell and the surgical staff of the A. E. F.

Hypochlorite solutions had been used for many years for the purpose of wound irrigation. Labarraque solution and Javel water were but two names under which sodium hypochlorite solution had become known in the course of the years. All these solutions were distinguished from Dakin solution by their high pH and by the large amount of excess alkali they contained. Sodium hypochlorite solution is very unstable unless it is buffered at high pH and contains excess alkali. Such a solution is much less effective and more corrosive than a solution buffered at a low pH and with lower alkalinity.

With the declining requirements for large amounts of fresh Dakin solution in the years after the World War, it became more and more impractical, in all but the largest hospitals, to prepare the small quantities required daily. Probably 90 per cent of all hospital pharmacies today supply, under the name of Dakin Solution, an irrigating fluid sometimes prepared from a commercial alkaline hypochlorite solution by diluting with water, and at other times prepared from Chloramine-T (sodium paratoluenesulfon-chloramide) by dissolving this chemical in water.

As the proportions for diluting liquid hypochlorites and for dissolving tablet form or powder Chloramine-T are not generally agreed upon, the composition of so-called "Dakin solution" prepared from these products varies over a wide range, as is evident from the accompanying tabulated data. It is not unlikely that a great deal of the controversy in clinical literature regarding the efficacy of Dakin solution may be traced to the astounding variations in solutions which are designated "Dakin solution" in the hospitals of this country.

On the other hand, Azochloramid, a recently developed chlorine compound, offers an excellent means of preparing a standard irrigating solution which does not show such a variation. Available as Azochloramid Saline Mixture 1:3300, it is so compounded that when a standard quantity is dissolved in a gallon of distilled water an isotonic irrigating solution is prepared containing sufficient phosphate buffer to hold it in the neighborhood of pH 7.4 and an Azochloramid concentration of 1:3300 —the equivalent of .0231 per cent available chlorine.

Despite the fact that the initial chlorine concentration of this solution is only approximately 5 per cent that of Dakin solution its stability, particularly in the presence of organic matter, is such that the chlorine in the form of Azochloramid remains potent in a wound for much longer periods than the chlorine in Dakin solution. This solution has come into vogue in the treatment of contaminated wounds not only because it is readily prepared with a minimum of time and effort but also because of the prolonged effectiveness of its chlorine when in contact with a wound surface or cavity. Much longer intervals between dressing changes are permissible, than if either true Dakin or Dakin substitutes are used. Also, when Azochloramid solution is protected from the light by storage in an amber bottle it retains its potency for much longer periods of time.

A survey was made recently where so-called "Dakin solutions" from 22 hospitals were carefully analyzed. Generally speaking, four kinds of solutions were encountered. Two of the 22 hospitals approached were able to supply true Dakin solution prepared by the original War-time Rockefeller Institute Method. In one hospital the U. S. Pharmacopeia method for preparing Dakin solution was in vogue. Nine hospitals used a commercial alkaline hypochlorite solution which they diluted in various proportions, and in ten hospitals Chloramine-T was dissolved in water and the finished solution distributed as "Dakin solution."

These data were compared with data obtained from the analyses of 30 samples of Azochloramid Saline irrigating solutions obtained from 30 other hospitals.

Realizing that any analytical figures referring to the composition of chlorine solutions can be considered reliable only if analyses are made without delay, all samples except those of Azochloramid solutions were obtained within a thirty-mile radius of New York City and analyzed the same day. When requesting samples of Azochloramid solutions from the hospital pharmacists, they were asked to supply samples of the solution actually in use and not freshly prepared samples. Thus, the so-called Dakin solutions analyzed in this survey were fresh or at the most two or three days old, whereas, the age of the samples of Azochloramid solutions ranged all the way up to nine and one-half months.

In the analyses of these solutions accepted methods were used and one sample of true Dakin solution was found to contain as much as .112 per cent of free alkali by titration whereas its pH was only 8.92. Another sample, prepared from commercial hypochlorite solution which contained as little as .01 per cent free alkali, had a pH of 11.1.

The chlorine concentration of these

solutions also varied widely. One sample prepared from commercial hypochlorite solution contained as little as .16 per cent active chlorine whereas the highest one contained as much as .589 per cent of chlorine. The free titrable alkalinity varied from .01 to .478 per cent, an extreme variation of one to almost fifty.

A similar variation was encountered in Chloramine-T samples. Here the least concentrated sample contained .153 per cent and the most concentrated contained .574 per cent of active chlorine. While Chloramine-T solutions do not contain any free alkali on titration with phenol phthalein as an indicator, the pH of the ten samples investigated varied from 7.9 to 9.8.

In comparing these figures with the data on the Azochloramid solutions which were obtained from solutions up to nine and one-half months old, it will be seen that no extreme variations are encountered.

Azochloramid Saline solution is prepared to contain .0231 per cent available chlorine, no free alkalinity, and should have a pH of 7.4 when made up with distilled water. The maximum variation from this standard was .0307 per cent for the sample containing the highest amount, or approximately 33 per cent more than it should have been. The minimum encountered was .018 per cent or approximately 20 per cent less than there should have been in the solution. The solution containing the most Azochloramid was one half again as strong as the solution which contained the least Azochloramid.

The variation in pH was from a minimum of 6.9 to a maximum of 7.5, a marked contrast to the variation in either of the two other solutions. This value is close to the physical neutral point which is also the physiological neutral point.

From experience collected in this laboratory it has been found that unless exposed to light the deterioration of Azochloramid solution is very slow. The sub-standard samples of Azochloramid, unless they were deliberately prepared with lower than recommended amounts of saline mixture, probably were not kept in amber bottles and deteriorated somewhat because of exposure to light.

In summary: Representative samples of true Dakin solution, various types of diluted hypochlorite solutions, Chloramine-T solutions and Azochloramid solutions, obtained from 52 hospitals, were investigated. Whereas the Azochloramid samples used were up to nine and one-half months old, samples of all other solutions were freshly prepared. A variation in chlorine concentration

HOSPITAL TYPE	APPROX. NO. OF BEDS	LOCATION MANAGEMENT		DESIGNATION OF CHLORINE SOLUTION	PREPARED FROM	STORAGE PERIOD WHEN TESTED	% ACTIVE CHLORINE	% FREE ALKALI PHENOLPHTHALEIN (GMS. NaOH/LITER)	pH
General	650	Non-Profit	S.Atlantic	Carrel-Dakin	RATINE SOLUTION PREPARED BY ROCKEFELLER INSTITUTE METHOD	Fresh	.415		
						2 Days	.410		
						3 Days	.390	.079	8.8
						1 Week	.384		
General	250	Non-Profit	N.Atlantic	Carrel-Dakin Violet A		Fresh	.472	.107	8.92
				Carrel-Dakin Violet B		Fresh	.470	None	8.5
				Carrel-Dakin Colorless A		Fresh	.436	.113	8.93
				Carrel-Dakin Colorless B		Fresh	.436	None	8.4
General	300	Non-Profit	N.Atlantic	"Dakin"	COMMERCIAL HYPOCHLORITE SOLUTION	Fresh	.589	.851	10.8
	200						.272	No Test	10.3
	175						.272	.0622	9.11
	375						.495	.048	10.71
	300	Church		"Dakin" U.S.P. #10	U.S.P. #10	Fresh	.554		
						10 Days	.500	.088	10.6
	2400	City		"Dakin"	COMMERCIAL HYPOCHLORITE SOLUTION	Fresh	.508	.01	11.1
	150	Non-Profit				Not given	.263	No Test	9.2
	450	Church					.165	.01	10.3
	186	Non-Profit				Fresh	.564	.21	9.0
	175					3 Days	.204	.478	9.87
General	475	City	N.Atlantic	"Dakin"	CHLORAMINE-T	3 Days	.546	None	8.86
	120	Non-Profit				Not Given	.285	"	9.0
	250						.24	"	8.9
	400					Fresh	.393	None	9.3
	350						.208	"	9.12
	700	City					.295	"	9.58
	206	Corp.				3 Days	.[illegible]	"	9.41
	150	Non-Profit				Fresh	.344	None	9.8
	206	Corp.					.262		8.79
	550	Non-Profit					.[illegible]		7.9

HOSPITAL TYPE	APPROX. NO. OF BEDS	LOCATION MANAGEMENT		DESIGNATION OF CHLORINE SOLUTION	PREPARED FROM	STORAGE PERIOD WHEN TESTED	% ACTIVE CHLORINE	% FREE ALKALI PHENOLPHTHALEIN (GMS. NaOH/LITER)	pH
General	[illegible]	[illegible]	Middle Atlantic	Azochloramid Saline	AZOCHLORAMID SALINE MIXTURE 1:3300	0 Days	.023	None	7.2
"	600	"	N.Atlantic	"		16 Days	.018	"	7.0
TB	125	County	N.Central	"		86 Days	.020	"	7.0
General	250	Non-Profit	Middle Atlantic	"		Not given	.023	"	7.4
TB	580	State	"	"		15 Days	.021	"	7.3
General	160	Non-Profit	"	"		44 Days	.019	"	7.3
General & TB	1200	City	S.Atlantic	"		23 Days	.019	"	7.1
General	2500	"	N.Atlantic	"		11 Days	.021	"	7.6
"	250	Non-Profit	S.Atlantic	"		8 Days	.022	"	7.5
"	190	"	Middle Atlantic	"		Not given	.027	"	7.4
"	250	"	"	"		" "	.022	"	7.4
"	275	"	"	"		"	.019	"	6.95
"	280	City	N.Central	"		"	.024	"	6.9
"	100	Non-Profit	Middle Atlantic	"	AZOCHLORAMID SALINE MIXTURE 1:3300	"	.023	"	6.9
"	250	Church	N.Atlantic	"		15 Days	.020	"	7.2
"	210	Non-Profit	"	"		60 Days	.022	"	7.1
"	600	Federal	S.Atlantic	"		6 Days	.0238	"	7.34
"	450	City	N.Central	"		Not given	.0238	"	7.40
"	180	Non-Profit	S.Atlantic	"		38 Days	.0217	"	7.31
"	105	"	"	"		Not given	.0206	"	7.20
"	420	State	N.Central	"		7 Days	.0201	"	7.28
TB	150	Corp.	"	"		52 Days	.0213	"	7.30
Isolation	430	City	"	"		28 Days	.0217	"	7.30
General	100	County	Western	"		29 Days	.0214	"	7.30
"	300	State	"	"		31 Days	.0225	"	7.15
"	600	Government	N.Central	"	AZOCHLORAMID SALINE MIXTURE 1:3300	10 Days	.0239	"	7.40
"	500	County	Western	"		9½ Mos.	.0188	"	7.38
"	165	Church	Middle Atlantic	"		1 No.	.0226	"	7.28
"	60	"	Western	"		16 Days	.0232	"	7.21
"	700	City	Middle Atlantic	"		8 Days	.0307	"	7.30

An analysis of the stability of various chlorine solutions as found in 52 representative hospitals.

and in pH of the Azochloramid solutions investigated appeared to be within reasonable limits and the incidence of samples varying from the normal was very small. On the other hand, the samples of so-called "Dakin solution" prepared from other chlorine preparations were found to have an extreme variation in chlorine concentration, a still larger variation in free alkali concentration and particularly in hydrogen ion concentration. The pH of all of these solutions was materially higher than that of true Dakin solution.

It is not unlikely that the controversy regarding the clinical effectiveness of Dakin solution has its origin in the fact that the name "Dakin solution" has been applied to such a wide variety of chlorine solutions, with important differences in composition and resulting clinical effectiveness.

Roche Introduces Syntrogel Capsules

Hoffman-La Roche, Inc., Nutley, N. J., has introduced new Syntrogel capsules for the treatment of gastric hyperacidity, which they claim can do the work of comparative massive doses of antacid liquids or powders. The action of the new product is said to be "to absorb and neutralize acid, mildly and without provocation to further acidity, to relieve flatulence, and to overcome spasm and hypersecretion."

The capsules are relatively small, available in cartons of 50 and 100. Dosage is extremely simple. One or two capsules are recommended for administration with water, immediately upon the appearance of hyperacidity or flatulence.

Three Products Added to Squibb Line

Riboflavin (Vitamin B_2 or G) is now being supplied by E. R. Squibb & Sons, New York, in synthetic form for oral use in capsules containing 1 milligram, or approximately 400 Bourquin-Sherman units each. The capsules are packaged in bottles of 25.

A source of hydrochloric acid in capsule form for the treatment of achlohydria (absence of hydrochloric acid in the gastric secretions) and hypochlorhydria (insufficient hydrochloric acid in the gastric secretions) has also been placed on the market by Squibb, in Glutamic Acid Hydrochloride Capsules Squibb, supplied in bottles of 100 and 500.

In the medical treatment of gastric ulcer and for the relief of simple excess acidity in the stomach, magnesium trisilicate has proved its value in a number of clinical trials in the United States, England and Canada. Developed by Dr. N. Mutch of Guy's Hospital, London, after extensive study of a number of silicates and preparations with similar colloidal properties, it has recently been placed on the market by Squibb in the form of a 7½ grain tablet slightly flavored with peppermint. Magnesium Trisilicate Squibb is administered orally, two hours after meals, in total dosage of 45 to 180 grains (6 to 24 tablets) daily. It is supplied in bottles of 100 and 1,000.

Refresher Course

A refresher course for dietitians will be held next summer at the New York Hospital, New York, N. Y., under the direction of Margaret Gillam. The course is open to dietitians who have worked for some time, and students will credit for the Master's Degree at Teachers College, Columbia University.

Illinois Dietitians to Meet Feb. 9-10

The midwinter meeting of the Illinois Dietetic Association will be held at the Drake Hotel in Chicago, Feb. 9 and 10.

The convention will open Friday afternoon with the following program: Dr. Robert Wood Keaton, head of the Department of Medicine, University of Illinois, will speak on "Obesity"; Dr. Harold Lueth, University of Illinois, will discuss some phase of nephritis and Dr. M. Herbert Barker, assistant professor of medicine at Northwestern University, will speak on the subject "The Role of Sulphur and Phosphorus in the Diet."

At the dinner meeting Friday evening Dr. C. A. Elvehjem, noted biochemist of the University of Wisconsin, will discuss "The Vitamin B Complex and Normal Nutrition."

Although definite topics and speakers cannot be given at this time, interesting administrative and educational programs are being planned for the Saturday morning and luncheon sessions.

A program of outstanding speakers, a display of commercial exhibits, and the excellent service and fine food for which the Drake Hotel is justly famous should attract a large group of dietitians from Illinois and the adjoining states.

WITH THE SUPPLIERS

Don Baxter, Inc., Glendale, Cal., has announced the appointment of Lloyd L. Ely, M.D., as medical director of its research and production laboratories. Dr. Ely has had wide experience in the development of therapeutic agents for use by the medical profession, having served for several years as director of the Department of Medical Therapeutics of Eli Lilly & Co., Indianapolis, and medical director of Merck & Co., New York.

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The American Hospital Supply Corporation, of Chicago, moved into completely rebuilt offices on Jan. 1. Over 15,000 square feet of space in the Merchandise Mart has been added to that already occupied by this company. Warehouse facilities have also been greatly enlarged.

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Air Reduction Company, Inc., New York City, has recently acquired the assets and business of The Ohio Chemical and Manufacturing Company of Cleveland, large producers and dispensers of medical gases and chemicals, and the apparatus and equipment for their use. The headquarters of the Ohio firm will continue to be located in Cleveland, and the business will be conducted by its existing personnel. All territories in the United States will be covered by the same representatives as in the past.

A pioneer in anesthetic research, Ohio Chemical has been responsible for many developments in this field of endeavor.

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Bert K. Naster of Electro Manufacturing Co., has been appointed chief engineer of a new Commercial Fluorescent Engineering Service. This service has been instituted by Electro to assist their distributors in planning and designing the most efficient fluorescent lighting available for all types of commercial installations.

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The Sixth International Heating & Ventilating Exposition will be held at Lakeside Hall, Cleveland, Ohio, from Jan. 22 to 26, with exhibits of equipment by more than 300 manufacturers. Among the products to be shown are: combustion apparatus, steam and hot water heating equipment, hydraulic apparatus, ventilating and air conditioning equipment, control appliances, and refrigerating machinery.

Four years after the introduction of their original A-B-D-G Capsule, E. R. Squibb & Sons, New York, have brought out a new, improved four-vitamin capsule of higher potency. In the New Squibb High Potency A-B-D-G Vitamin Capsule, a rational balance has been struck in relation to the amounts of each vitamin incorporated in the capsule, one capsule supplying the full estimated daily adult prophylactic requirement of vitamins A, B_1 and D, together with definite amounts of certain vitamin B complex factors (including riboflavin, nicotinic acid, vitamin B_6 and the filtrate factor) the absolute daily requirement of which has not yet been determined.

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The election of Maynard D. Church as a vice-president of Worthington Pump and Machinery Corporation, Harrison, N. J., has been announced by H. C. Beaver, the corporation's president.

Hospital Expansion Plan

(*Continued from page* 10)

suggested the advisability of a limited program, concentrating for the present on the construction of hospitals and health centers in communities where the need for such facilities is greatest. It is reported that this plan contemplates construction of hospitals by the federal government, wholly at its expense, where the need exists and where the locality is willing and able to maintain and operate the institution after it is built. I understand that the details of this plan have yet to be worked out and that is being carefully studied by the Interdepartmental Committee. It is therefore premature to hazard opinions about its merits.

"The health bill emphasized the need for constructing hospitals in certain areas. It also made provision for small temporary grants, disappearing after three years, to assist the communities in taking over financial responsibility for operation and maintenance. Grants-in-aid for health and medical services are proposed in the bill on a 'variable grant' basis, the federal grants ranging from 33⅓ per cent for the wealthiest state to 66⅔ per cent for the poorest state. It was intended that this formula should enable even the poorest area to participate substantially in the program. If this formula still gives too much to the wealthy states and too little to the poor states, there might be justification for spreading the range of 'variable grants' still further."

NEW EQUIPMENT

Adjustable Shower Head

An adjustable shower head for modern water therapy has just been introduced by Yates Manufacturing Co. An exclusive control device is said to make immediate adjustment of both the volume and the type of spray, giving a complete range from vapor to torrent.

The new shower head is made of red brass and bronze to resist corrosion, with duPont Neoprene gaskets instead of leather or rubber washers. The water outlet slots are wider at the bottom than the top to prevent clogging.

New Rubber Flooring

The development of a moderately priced rubber floor covering has been announced recently by the Goodyear Tire & Rubber Co. Identified as medium gauge Wingfoot Flooring, it is available in rolls of 36-inch width, 40 to 45 yards in length, gauge .095 inches, in seven colors—red and white, plain black, black and white, two-tone medium gray, green and white, brown and white, and two-tone light tan.

Applied in the same manner as linoleum, the new flooring is resilient to foot traffic and can be installed to harmonize with any color scheme desired. It is said to be both fire and stain resistant.

Dishwashing Machines

The Autosan Dishwashing Division of Colt's Patent Fire Arms Manufacturing Company has recently announced two additions to its line of dishwashing machines—Models RX-2 and RX-2P. The models are identical with the exception that the RX-2P features a front panel covering the motor and pump compartment, and thermostatic control.

Designed to give big machine efficiency, the machines are simple to operate and easy to clean. There are no moving inside parts; capped type spray tubes come out without the use of tools, and scrap trays lift out without removing spray tubes. The pump drives 140 gallons of wash solution per minute on the tableware from above and below.

Both models are finished with automatic rinse trip, easily cleaned pump, an adjustable foot, and a 30 gallon capacity tank.

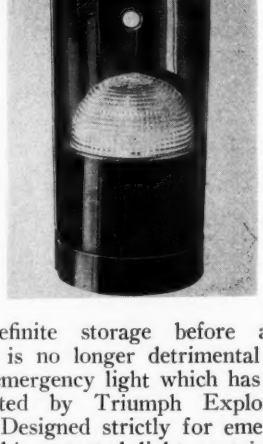
New Floor Fan

A new fan called Floor-Aire, primarily designed for floor or low placement, has been announced by the Westinghouse Electric & Mfg. Company, to complete its line of desk, adjustable-pedestal, and commercial fans.

The Floor-Aire fan is housed in a walnut-finish grilled cabinet and may be placed anywhere on the floor without inconvenience to occupants of the room. The grilles are vertical steel wires, ⅝ inch apart. Felt feet protect floors as well as the cabinet base.

Deep-pitched, ultra-quiet Micarta blades insure maximum air circulation with a minimum of sound. The unit is light in weight and portable.

Emergency Light



Indefinite storage before actual usage is no longer detrimental to a new emergency light which has been perfected by Triumph Explosives, Inc. Designed strictly for emergencies, this patented light contains all the qualities of the old dry cell with the important advantage that no deterioration can take place before the light is required for use.

The new battery is similar to the standard type of lantern battery both

in appearance, method of contact and voltage capacity. The main difference is that the cells are packed and sealed in a dry state and activated only by striking the bottom of the battery against any solid object. No deterioration can possibly take place because, until the battery is struck, the cells do not become energized.

This unit in specific form has been approved by Underwriters' Laboratories, Electrical Testing Laboratories of New York and various state commissions.

1940 Model Silentaire

Positive circulation of room air can now be obtained with the new 1940 model Silentaire, the electrically-operated window ventilator that ventilates, circulates and filters the air, provides comfort cooling by natural methods and eliminates outside noises. Agitation of room air is effective up to 50 feet. A thermostat provides for speed control of the discharge. Adjustable louvres permit direction of air current as desired and prevent drafts.

Capacity has been increased to 650 cubic feet per minute anemometer volume. A new controllable mixing damper permits blending of outside and room air in correct proportions for each season of the year. During hot summer months and cold winter months, excess outside air is prevented from entering the room. At night, the damper may be opened wide to flood the room with cool night air.

The new model is weatherproof. The mechanism is silent in operation and the inside of the cabinet is treated with a special sound-absorbing material the action of which in absorbing noise is likened to that of a sponge in water.

Made by Berger Manufacturing Division, Republic Steel Corporation.

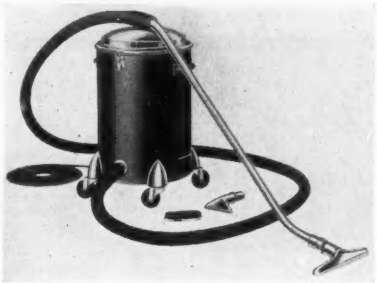
Portable Ultraviolet Meter

A new portable alternating-current-operated ultra-violet measuring device, useful for measuring the output of various types of ultra-violet sources has been announced by Westinghouse Electric & Mfg. Co.

Used with a tantalum phototube, the meter is particularly useful in measuring the output of ultra-violet lamps; with a titanium phototube the meter may be used for measuring ultra-violet radiation of the sun, or employed to determine the proper time of exposure for sun baths or sun lamp treatments; with a platinum phototube the device measures radiations in the ozone-producing region.

Amount of radiation is determined in the new meter by the integrating method and indicated by a mechanical counter. The number of counts registered in given time indicates the intensity of ultra-violet radiations impinging upon the phototube, placed at a given distance from the source at a rate proportional to the exposure time.

Heavy-Duty Vacuum Cleaner



A new heavy-duty vacuum cleaner, the Premier Imperial, has recently been placed on the market by the Electric Vacuum Cleaner Co.

The manufacturers claim several distinctive features for the new machine: silent operation linked with powerful suction that lifts out embedded dirt from the heaviest rugs; simple to start and stop from a single switch; easy to use and to clean. Although of the enclosed type, the motor is readily accessible for inspection or cleaning of the brushes. Standard attachments are a hose, floor rod, upholstery tool, upholstery tool brush, and the floor-cleaning tool.

New Oakite Material

Oakite Products, Inc., has recently developed a new material for washing dishes, glassware and silverware.

Because of its unusual lime solubilizing properties, the material, known as Oakite Composition No. 63, is reported to successfully solve two problems common to many hospitals, particularly those in hard water areas. By keeping in suspension a considerable amount of the insoluble constituents of hard water, the material substantially helps prevent the formation of hard water spots and film on dishes and glassware. It also reduces lime scale accumulations and other hard water deposits in dishwashing machine interiors, thus effectively retarding clogging of pipes and spray jets.

Also important, the makers claim, is the fact that the wetting-out characteirstics and free-rinsing qualities of the material make it highly effective for both dishwashing and general maintenance cleaning work in soft water sections.

Changes in Administrative Personnel

DR. HARRY J. BRAYTON, superintendent of the Onondaga County Sanatorium, Syracuse, N. Y., for 24 years, has resigned from that position because of ill health.

E. REID CADDY, administrative assistant of St. Luke's Hospital, New York City, has been appointed medical director of the South Baltimore General Hospital, Baltimore, Md.

IRVING E. CHARLESWORTH has been appointed medical director of the Napa State Hospital, Imola, Cal., succeeding the late J. M. SCANLAND, M.D. Dr. Charlesworth has been a member of the hospital for thirteen years, and has served as assistant superintendent since 1932.

B. F. PETERSON, M.D., assistant superintendent of Eastern State Hospital, Knoxville, Tenn., has been named superintendent of Western State Hospital, Bolivar, Tenn., succeeding J. R. WILSON, M.D., who resigned recently.

LOUIS J. GARCIA, M.D., in charge of Tampa's tuberculosis clinic since it was opened in 1937, is the director of the new tuberculosis hospital for children in that city.

HELEN MAXWELL has been named superintendent of Bluffton Community Hospital, Bluffton, Ohio, succeeding STELLA BURKHOLDER, who recently resigned.

ANTHONY M. FRATIS, Oakland, Cal., has been appointed superintendent of Yuba County Hospital, Marysville, Cal., succeeding W. W. RICHARDS, M.D., resigned.

SISTER M. SUITBERTHA, superintendent for the last eight years of Mary Immaculate Hospital Jamaica, N. Y., will exchange posts with SISTER M. EUGENIA, superintendent of St. Catherine's Hospital, Brooklyn.

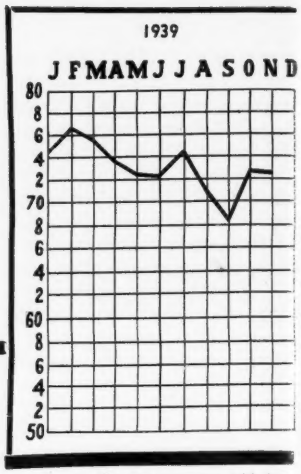
CHARLES G. MORGAN, M.D., has been appointed director of the Ohio County Tuberculosis Sanatorium, Wheeling, W. Va., succeeding E. E. CLOVIS, M.D., who resigned recently.

WILLIAM B. NUGENT has been appointed manager of the Des Moines Veterans Hospital, Des Moines, Ia., succeeding CHARLES G. BECK, who has been transferred to the Hines, Ill., unit.

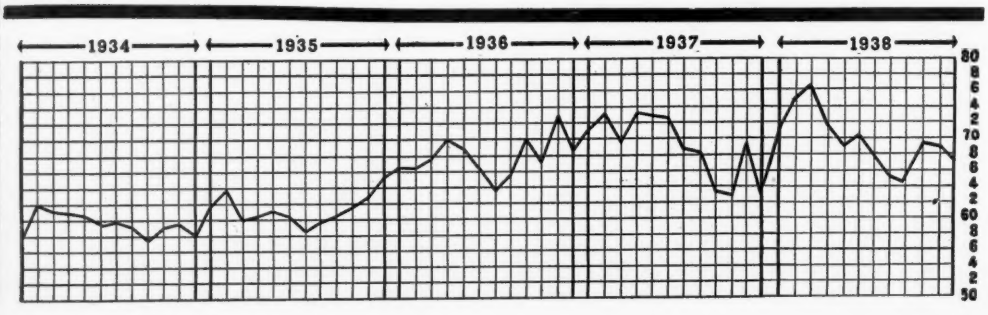
MARY L. MARGERUM, R.N., has been appointed superintendent of the Calumet Memorial Hospital, Laurium, Mich., succeeding MAE SURA, R.N., who resigned recently.

How's Business?

Since January 1, 1938, the charts and figures on this page are based on reports from 100 hospitals located in 48 states. There is, therefore, a marked increase in the total receipts and expenditures from previous months.



Total Daily Average Patient Census		Receipts from Patients		Operating Expenditures	
April, 1934	10,993	April, 1934	1,529,596.00	April, 1934	1,723,237.00
May, 1934	10,869	May, 1934	1,549,902.00	May, 1934	1,763,407.00
June, 1924	10,638	June, 1934	1,543,631.00	June, 1934	1,757,885.00
July, 1934	10,701	July, 1934	1,495,036.00	July, 1934	1,800,817.00
August, 1934	10,620	August, 1934	1,469,074.00	August, 1934	1,782,184.00
September, 1934	10,309	September, 1934	1,412,009.00	September, 1934	1,770,998.00
October, 1934	10,524	October, 1934	1,537,002.00	October, 1934	1,815,650.00
November, 1934	10,634	November, 1934	1,520,135.00	November, 1934	1,830,598.00
December, 1934	10,376	December, 1934	1,446,092.00	December, 1934	1,846,180.00
January, 1935	11,062	January, 1935	1,506,382.00	January, 1935	1,883,938.00
February, 1935	11,426	February, 1935	1,562,412.00	February, 1935	1,888,570.00
March, 1935	10,731	March, 1935	1,563,621.00	March, 1935	1,773,343.00
April, 1935	10,858	April, 1935	1,536,286.00	April, 1935	1,813,947.00
May, 1935	10,946	May, 1935	1,565,526.76	May, 1935	1,826,149.93
June, 1935	10,802	June, 1935	1,528,129.00	June, 1935	1,810,623.60
July, 1935	10,662	July, 1935	1,514,901.00	July, 1935	1,736,856.00
August, 1935	10,765	August, 1935	1,522,877.00	August, 1935	1,795,539.00
September, 1935	10,728	September, 1935	1,516,305.00	September, 1935	1,828,619.00
October, 1935	10,989	October, 1935	1,534,179.00	October, 1935	1,831,115.00
November, 1935	11,079	November, 1935	1,546,341.00	November, 1935	1,849;120.00
December, 1935	11,324	December, 1935	1,552,421.00	December, 1935	1,897,615.00
January, 1936	11,414	January, 1936	1,561,623 00	January, 1936	1,934,852.00
February, 1936	11,408	February, 1936	1,559,611.00	February, 1936	1,929,623.00
March, 1936	11,463	March, 1936	1,612,982.00	March, 1936	1,954,182.00
April, 1936	11,894	April, 1936	1,915,277.00	April, 1936	1,897,523.00
May, 1936	11,304	May, 1936	1,536,408.00	May, 1936	1,871,964.00
June, 1936	10,545	June, 1936	1,657,474.00	June, 1936	1,921,027.68
July, 1936	9,863	July, 1936	1,490,688.00	July, 1936	1,689,696.00
August, 1936	10,004	August, 1936	1,535,688.00	August, 1936	1,847,736.00
September, 1936	10,137	September, 1936	1,457,640.00	September, 1936	1,896,120.00
October, 1936	9,454	October, 1936	1,520,719.21	October, 1936	1,918,931.76
November, 1936	10,204	November, 1936	1,465,067.52	November, 1936	1,817,101.44
December, 1936	9,687	December, 1936	1,272,765.60	December, 1936	1,568,264.40
January, 1937	10,771	January, 1937	1,539,576.00	January, 1937	1,864,748.16
February, 1937	10,941	February, 1937	1,516,917.00	February, 1937	1,890,667.44
March, 1937	10,990	March, 1937	1,672,002.72	March, 1937	1,969,652.16
April, 1937	11,703	April, 1937	1,694,262.24	April, 1937	2,180,839.60
May, 1937	11,002	May, 1937	1,776,046.32	May, 1937	1,988,845.92
June, 1937	11,403	June, 1937	1,646,881.92	June, 1937	1,990,221.12
July, 1937	10,914	July, 1937	1,728,112.32	July, 1937	1,933,971.84
August, 1937	10,712	August, 1937	1,773,724.32	August, 1937	2,066,890.32
September, 1937	9,805	September, 1937	1,496,919.68	September, 1937	2,058,107.72
October, 1937	10,004	October, 1937	1,679,252.40	October, 1937	2,140,030.08
November, 1937	11,590	November, 1937	1,624,680.72	November, 1937	1,958,306.24
December, 1937	8,903	December, 1937	1,491,132.24	December, 1937	1,891,580.40
January, 1938	14,177	January, 1938	2,285,605.34	January, 1938	2,694,605.32
February, 1938	14,944	February, 1938	2,202,334.78	February, 1938	2,618,517.39
March, 1938	17,579	March, 1938	2,611,169.58	March, 1938	2,922,850.00
April, 1938	14,465	April, 1938	2,312,768.26	April, 1938	2,735,879.56
May, 1938	14,194	May, 1938	2,481,591.59	May, 1938	2,777,780.72
June, 1938	13,939	June, 1938	2,304,268.32	June, 1938	2,704,438.11
July, 1938	13,976	July, 1938	2,529,686.40	July, 1938	2,915,889.82
August, 1938	13,736	August, 1938	2,337,295.65	August, 1938	2,973,112.41
September, 1938	13,138	September, 1938	2,126,627.84	September, 1938	2,546,495.02
October, 1938	14,103	October, 1938	2,433,872.54	October, 1938	3,002,474.11
November, 1938	13,685	November, 1938	2,277,880.76	November, 1938	2,750,654.42
December, 1938	12,877	December, 1938	2,162,011.03	December, 1938	2,476,764.23
January, 1939	15,133	January, 1939	2,457,434.28	January, 1939	2,833,180.02
February, 1939	14,886	February, 1939	2,282,062.33	February, 1939	2,563,253.61
March, 1939	14,585	March, 1939	2,524,429.49	March, 1939	2,717,146.15
April, 1939	14,293	April, 1939	2,463,491.55	April, 1939	2,646,285.92
May, 1939	14,702	May, 1939	2,669,878.14	May, 1939	2,831,340.72
June, 1939	14,266	June, 1939	2,936,732.81	June, 1939	3,225,065.63
July, 1939	14,952	July, 1939	2,558,450.00	July, 1939	2,878,193.93
August, 1939	13,419	August, 1939	2,395,063.49	August, 1939	2,614,095.23
September, 1939	13,827	September, 1939	2,355,545.45	September, 1939	2,803,382.08
October, 1939	14,536	October, 1939	2,560,529.68	October, 1939	2,852,221.88
November, 1939	14,908	November, 1939	2,536,426.56	November, 1939	2,983,409.38



Average Occupancy on 100 Per Cent Basis	
December, 1932	52.6
January, 1933	56.2
February, 1933	57.3
March, 1933	57.2
April, 1933	55.7
May, 1933	56.0
June, 1933	56.1
July, 1933	54.7
August, 1933	54.9
September, 1933	54.4
October, 1933	55.3
November, 1933	56.0
December, 1933	54.7
January, 1934	57.9
February, 1934	62.0
March, 1934	61.6
April, 1934	61.5
May, 1934	60.8
June, 1934	59.5
July, 1934	59.9
August, 1934	59.4
September, 1934	57.7
October, 1934	58.9
November, 1934	59.5
December, 1934	58.1
January, 1935	61.9
February, 1935	63.96
March, 1935	60.07
April, 1935	60.78
May, 1935	61.09
June, 1935	60.02
July, 1935	58.6
August, 1935	59.8
September, 1935	60.1
October, 1935	61.4
November, 1935	62.1
December, 1935	65.8
January, 1936	66.2
February, 1936	66.18
March, 1936	67.6
April, 1936	70.0
May, 1936	69.1
June, 1936	66.3
July, 1936	63.9
August, 1936	65.7
September, 1936	70.0
October, 1936	67.1
November, 1936	72.5
December, 1936	68.8
January, 1937	70.9
February, 1937	73.05
March, 1937	69.98
April, 1937	73.0
May, 1937	72.48
June, 1937	72.35
July, 1937	68.58
August, 1937	68.05
September, 1937	63.25
October, 1937	63.09
November, 1937	69.8
December, 1937	63.0
January, 1938	71.5
February, 1938	74.8
March, 1938	76.12
April, 1938	71.9
May, 1938	69.86
June, 1938	70.7
July, 1938	67.68
August, 1938	65.80
September, 1938	65.17
October, 1938	69.45
November, 1938	69.20
December, 1938	67.95
January, 1939	74.57
February, 1939	76.47
March, 1939	75.84
April, 1939	73.93
May, 1939	72.56
June, 1939	72.33
July, 1939	74.05
August, 1939	70.87
September, 1939	68.10
October, 1939	72.67
November, 1939	72.33

IN THE SUPPLIERS' LIBRARY

No. 804. A descriptive folder describing the advantages of **Oakite Composition No. 63** in washing dishes, glassware and silverware, has just been issued by Oakite Products, Inc.

No. 803. Manson, Inc., has issued a four-page bulletin on its new **butter cutter and dispenser.**

No. 802. The **"Exerow"** machine, an exercise machine which combines the motions of both rowing and riding, is the subject of a folder recently issued by Battle Creek Equipment Company.

No. 801. Davis & Pitmann Ltd. have released a folder on their line of **"Salvus"** sutures, which are prepared by the closed tube process of heat sterilization in vacuum.

No. 800. A new **moisture detector** is the subject of a folder recently issued by the Colloid Equipment Company, Inc.

No. 799. Beach-Russ Company has released a new bulletin on its line of **portable vacuum pumps** for laboratory and test work.

No. 798. The Celotex Company has published a booklet entitled "Less Noise, Better Hearing." Contents include: "Selecting an Acoustical Material"; **"Celotex Acoustical Products";** "Noise Quieting" and "Acoustical Correction." A new edition, Vol. 6, No. 6, of "The Quiet Forum" has also been released.

No. 797. Now available from The Tablet & Ticket Co. is a 36-page catalog illustrating and describing the firm's complete line of **changeable letter signs.** Price list is included.

No. 796. Connell Apparatus has published a book on the technique of **anesthesia administration.** Chapter headings include: "Nitrous Oxide, Ethylene"; "Cyclopropane"; "Ether"; "Oxygen"; "Carbon Dioxide"; "Helium" and "Care of Apparatus."

No. 795. Jewett Refrigerator Co. has for distribution a new broadside on **hospital refrigerators** and ice cube makers.

No. 794. Hygrade Sylvania Corporation has issued two folders describing and illustrating two new **fluorescent lighting units,** the Miralume HF-100 and Miralume HF-200.

No. 790. Swartzbaugh Mfg. Co. has published new catalog sheets on its new 1000, and 2000 and 3000 series **food conveyors.**

Request to HOSPITAL MANGEMENT will bring these new folders and latest information about equipment and supplies. Ask for them by number convenience.

No. 788. Literature on Buckeye **surgical soap** and details regarding a free offer of a soap dispenser are available from the Davies-Young Soap Co.

No. 781. Continental Coffee Co. has recently published a folder describing and illustrating its Continental Twin **urn equipment.**

No. 775. A folder published recently by the Toastmaster Products Div. of McGraw Electric Co. describes the firm's line of **electric appliances**—toasters, waffle bakers, griddles and roll warmers. Also available is a 16-page booklet, **"Toast Treats for the Hospital Diet,"** which includes many suggestions and recipes for toast dishes and sandwiches.

No. 772. Wilmot Castle Company has for distribution a new folder on its **water sterilizers.** Chief advantages claimed are the new recessed panel which gives "centralized control," and two openings in the wall instead of several.

No. 768. The features and advantages of **concentrated orange juice** are told in a folder published by Citrus Concentrates, Inc.

No. 757. Fixt Products has recently issued two small pamphlets in which are featured two of the company's products **—Fixt waffles and griddle cakes.**

No. 748. The features and uses of **Lysol disinfectant** are described in a new leaflet recently issued by Lehn & Fink Products Corporation.

No. 747. **"What Every Hospital Buyer Should Know About Feathers"** is the subject of a 12-page booklet recently published by Will Ross, Inc., for distribution among hospital superintendents and buyers.

No. 742. **"Hospital Housekeeping and Cleanliness"** is the subject of a new 48-page booklet recently issued by Colgate-Palmolive-Peet Co. The book contains instructions on the maintenance of exterior surfaces, floors, walls, plumbing fixtures, rooms, wards, lobbies, etc. One section is devoted to the operation of the power laundry and another to the removal of all types of stains. Included with the book is a **"Simplified Hospital Cleanliness Chart"** equipped with a hanger so that it may be displayed for easy reference.

No. 668. **"Lighting in the Surgery,"** a new catalog of surgical lighting equipment, has been published by the American Sterilizer Company.

No. 646. **"Cellu Dietetic Products for Sugar and Starch-Restricted Diets."** A 40-page catalog of foods, scales, insulin, insulin equipment and recipes for sugar and starch-restricted diets. Chicago Dietetic Supply House, Inc.

No. 518. **"A Complete System of Medical Records for the Hospital."** A new booklet presenting a check-list of approved forms which comprise the clinical chart of the patient; also those which are used in the admitting, accounting and other departments to form a complete system. Prepared by the Physician's Record Company.

No. 441. **"Sanitation Products for the Hospital."** A complete catalogue of Surgical and Baby Soaps and their dispensers, Baby Oil, Disinfectants, Floor Finishes, Floor Waxes, Furniture Polish, and other Hospital and Institutional supplies. The Huntington Laboratories.

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Please send me, without obligation, the booklets as listed in the Suppliers' Library, the numbers of which are circled below:

804	801	798	795	788	772	748	668	441
803	800	797	794	781	768	747	646	
802	799	796	790	775	757	742	518	

Name..... Position.....

Hospital .....

Address .....

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CLASSIFIED ADVERTISEMENTS

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MEDICAL DIRECTOR: Small southern hospital for treatment of mild mental, alcoholic and drug addicts. Southerner and Protestant preferred. North Carolina license. Salary open. We do not charge a registration fee. New York Medical Exchange, 489 Fifth Avenue, New York City.

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PRINCIPAL, SCHOOL OF NURSING: College graduate, with executive ability and experience in large schools of nursing. 350-bed hospital, mid-west. Desirable connection and salary. Interstate Hospital and Nurses Bureau, 332 Bulkley Building, Cleveland, Ohio.

RECORD LIBRARIAN: 175-bed general hospital, Michigan. (B) 200-bed Maryland hospital. (C) 100-bed Pennsylvania hospital. Interstate Hospital and Nurses Bureau, 332 Bulkley Building, Cleveland, Ohio.

SUPERINTENDENT OF NURSES: (A) 200-bed metropolitan hospital; approved training school. Degree and experience essential. Salary open. (B) Small hospital—all graduate staff, New York City. About 30 years old. Executive experience necessary. $1,800. We do not charge a registration fee. New York Medical Exchange, 489 Fifth Avenue, New York City.

POSITIONS OPEN

SUPERINTENDENT-NURSE: Small hospital. Pennsylvania R.N. Executive experience necessary. Salary open. We do not charge a registration fee. New York Medical Exchange, 489 Fifth Avenue, New York City.

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World's largest sharpeners of surgical blades.

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